Nos. 84-1353, 84-1354.

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# In the Supreme Court of the United States.

OCTOBER TERM, 1984.

No. 84-1353.

JAMES P. KARTELL, M.D., ET AL.,
PETITIONERS,
*v.*
BLUE SHIELD OF MASSACHUSETTS, INC.
RESPONDENT.

No. 84-1354.

GRANT V. RODKEY, M.D., ET AL.,
PETITIONERS,
*v.*
BLUE SHIELD OF MASSACHUSETTS, INC.,
RESPONDENT.

## Respondent's Brief in Opposition to Petitions for Certiorari.

DANIEL O. MAHONEY,
*Counsel of Record*,
PALMER & DODGE,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

REGINALD H. HOWE,
Suite 2200,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

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## Questions Presented.

Both petitions for certiorari fundamentally ask this Court to consider doing what the court of appeals refused to do: "create new potentially far-reaching law" on whether and under what circumstances contracts which simply set the price of the transaction at hand may violate § 1 of the Sherman Act. *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 928 (CA1 1984) ("*Kartell VI*") (PA14).[1]

Blue Shield of Massachusetts, Inc. (Blue Shield) was established under a special act for the purpose of "furnishing medical services at low cost to members of the public who become subscribers . . . ." Mass. St. 1941, c. 306, preamble. The contracts between Blue Shield and its participating physicians, and between Blue Shield and its subscribers, require Blue Shield participating physicians in most instances to accept Blue Shield payments as payment-in-full for covered services rendered to Blue Shield subscribers, and prohibit participating physicians from making additional charges to subscribers, a practice known as "balance billing."

This case presented three basic issues regarding the prohibition on balance billing: (1) whether it is a "contract . . . in restraint of trade" in violation of § 1 of the Sherman Act, 15 U.S.C. § 1; (2) whether it is immune from antitrust attack under the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1943), and its progeny; and (3) whether it is exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

In a unanimous opinion by Breyer, J., the Court of Appeals for the First Circuit, bypassing the immunity and exemption issues, proceeded directly to the antitrust merits. *Kartell VI*, 749 F.2d at 924 (PA5). It held that "Blue Shield in essence

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[1] See *infra*, p. 4, fn. 3, for explanation of citation forms used in this brief.

'buys' medical services for the account of [its subscribers]" (*id.* at 925 (PA7)), that "the lawfulness of the [ban on balance billing] stems from the fact that it is an essential part of the price bargain between buyer [Blue Shield] and seller [participating physician]" (*id.* at 928 (PA14)), and that whether the "price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist [assuming that the price is not predatory]." *Id.* Accordingly, relying on a long line of analogous cases and considerable scholarly authority (see *infra*, pp. 10-13), the court of appeals "appl[ied] mainstream antitrust doctrine" (*id.* at 930 (PA18)) and held that the ban on balance billing was not a "contract in restraint of trade" within the meaning of § 1 of the Sherman Act regardless of Blue Shield's alleged market power.

## Table of Contents.


| | |
|---|---|
| Opinions below | 1 |
| Pertinent statutes | 2 |
| Statement of the case | 3 |
| I. Proceedings below | 3 |
| II. Relevant facts | 6 |
| Summary of argument | 9 |
| Argument | 10 |
| I. The decision of the Court of Appeals is in accordance with similar decisions of this Court, four other courts of appeals, and the weight of scholarly comment | 10 |
| II. Since the ban on balance billing is now a state statutory prohibition, further review by this Court is unwarranted | 17 |
| Conclusion | 19 |
| Appendix | follows page 19 |


## Table of Authorities Cited.

CASES.


| | |
|---|---|
| Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) | 14, 15 |
| Blue Cross & Blue Shield v. Michigan Association of Psychotherapy Clinics, 1980-2 Trade Cases (CCH) ¶ 63,351 (E.D. Mich. 1980) | 11n, 12 |
| Cook v. Hudson, 429 U.S. 165 (1976) | 18 |
| Dandridge v. Williams, 397 U.S. 471 (1970) | 5n |

Davidowitz v. San Diego County Dental Society, 1983-1 Trade Cases (CCH) ¶ 65,231 (S.D. Cal. 1983) 12
Feldman v. Health Care Service Corp. 562 F.Supp. 941 (N.D. Ill. 1982) 12, 17
Grant V. Rodkey, et al. v. Blue Shield of Massachusetts, Inc., et al., United States District Court for the District of Massachusetts, No. 82-317-C 3n
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) 11, 13, 15n
Hoover v. Ronwin, 467 U.S. , 104 S.Ct. 1989, 80 L.Ed.2d 590 (1984) 18
Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. , 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984) 16
Kartell v. Blue Shield of Massachusetts, Inc., 592 F.2d 1191 (CA1 1979) (Kartell I) 4
Kartell v. Blue Shield of Massachusetts, Inc., 384 Mass. 409, 425 N.E.2d 313 (1981) (Kartell II) 1, 2, 4, 5, 6
Kartell v. Blue Shield of Massachusetts, Inc., 542 F. Supp. 782 (D. Mass. 1982) (Kartell III) 2, 4, 5, 14n
Kartell v. Blue Shield of Massachusetts, Inc., 687 F.2d 543 (CA1 1982) (Kartell IV) 4, 5
Kartell v. Blue Shield of Massachusetts, Inc., 582 F. Supp. 734 (D. Mass. 1984) (Kartell V) 4, 5, 7, 9, 14n
Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922 (CA1 1984) (Kartell VI) 4, 5, 7, 9, 12, 13 et seq.
Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., 675 F.2d 502 (CA2 1982) (*per curiam*) (affirming 518 F.Supp. 1100 (D. Conn. 1981) 11, 12, 13
Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan, 1982-2 Trade Cases (CCH) ¶ 64,801 (E.D. Mich. 1982) 12
Mulhearn v. Rose-Neath Funeral Home, Inc., 512 F. Supp. 747 (W.D. La. 1981) 10

Nelson v. Blue Shield of Massachusetts, Inc., 377 Mass. 746, 387 N.E.2d 589 (1979) 6
Parker v. Brown, 317 U.S. 341 (1943) 4
Pennsylvania Dental Association v. Medical Service Association of Pennsylvania, 745 F.2d 248 (CA3 1984), *pet. for cert. filed*, 53 U.S.L.W. 3619 (No. 84-1296, February 13, 1985) 11
Proctor v. State Farm Mutual Insurance Co., 675 F.2d 308 (CADC 1982) *cert. denied*, 459 U.S. 839 (1982) 10
Quality Auto Body v. Allstate Insurance Co., 660 F.2d 1195 (CA7 1981), *cert. denied*, 455 U.S. 1020 (1982) 10, 12
Royal Drug Co. v. Group Life & Health Insurance Co., 737 F.2d 1433 (CA5 1984), *cert. denied*, 105 S.Ct. 912 (1985) 11
Sausalito Pharmacy, Inc. v. Blue Shield of California, 677 F.2d 47 (CA9 1982) (*per curiam*) (affirming 544 F.Supp. 230 (N.D. Cal. 1981)), *cert. denied*, 459 U.S. 1016 (1982) 11, 12, 13
Sitkin Smelting and Refining Co. v. FMC Corp., 575 F.2d 440 (CA3 1978), *cert. denied*, 439 U.S. 866 (1978) 10
Triangle Improvement Council v. Ritchie, 402 U.S. 497 (1971) 18
United States v. New York Telephone Co., 434 U.S. 159 (1977) 5n
United States v. Trenton Potteries Co., 273 U.S. 392 (1927) 13, 14

STATUTES.

*Federal*:

15 U.S.C. § 1 3, 4, 5, 10, 13, 17
15 U.S.C. § 2 3

15 U.S.C. §§ 1011-1015 4, 5
42 U.S.C. § 1395j et seq. 8
Supreme Court Rule 17.1 13

*State*:

Massachusetts General Laws
c. 93A 8
c. 176B 2, 6
c. 176B, § 7 2
c. 176B, § 12 8
Mass. St. 1941, c. 306, preamble 6
Mass. St. 1984, c. 192, § 1 2, 17, 18n

MISCELLANEOUS.

P. Areeda, *Antitrust Analysis*, pp. 530-531 (1981) 13

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**Respondent's Brief in Opposition to Petitions for Certiorari.**

## Opinions Below.

Both petitions for certiorari fail to append all pertinent opinions below as required by Rule 21(k)(ii), particularly: *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 384 Mass. 409, 425

N.E.2d 313 (1981) ("*Kartell II*") (answering certified questions of state law); and *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 542 F.Supp. 782 (D. Mass. 1982) ("*Kartell III*") (granting in part defendants' motion for summary judgment). These opinions are set forth in the appendix to this brief.

**Pertinent Statutes.**

In addition to the statutes cited by petitioners, this case involves the state enabling legislation for Blue Shield, Mass. Gen. Laws, c. 176B, as amended, the pertinent parts of which are set forth in the appendix to this brief. Of particular importance in connection with the petitions for certiorari is the recent amendment to Mass. Gen. Laws, c. 176B, § 7 (Mass. St. 1984, c. 192, § 1, effective July 12, 1984), making the Blue Shield ban on balance billing an express state statutory prohibition. This amendment was passed in response to the decision of the district court in this case and prior to the decision of the court of appeals for which certiorari is sought. See *infra*, pp. 17-18. The amendment provides in relevant part:

> No participating physician or other participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the amount of compensation determined and allowed by [Blue Shield] pursuant to the applicable method of compensation approved by the commissioner [of insurance], except [in certain limited circumstances not here material].

## Statement of the Case.

### I. Proceedings Below.

This action was originally brought by four Massachusetts physicians, two of whom were Blue Shield participating physicians and two of whom were not, for injunctive relief from alleged violations of §§ 1 and 2 of the Sherman Act by Blue Shield and by Blue Cross of Massachusetts, Inc. ("Blue Cross").[2] Subsequently the Massachusetts Medical Society (the "Medical Society"), which has sponsored and financed this and related cases from the outset, and two additional Massachusetts physicians were allowed to intervene as parties plaintiff, and the Massachusetts Commissioner of Insurance (the "Commissioner") was allowed to intervene as a party defendant.

On the merits, plaintiffs and intervenor-plaintiffs (the petitioners before this Court) principally challenged two practices of Blue Shield and one of Blue Cross: (1) the refusal of Blue Shield to provide benefits for services rendered by non-participating physicians except in an emergency or outside Massachusetts; (2) the refusal of Blue Cross to provide benefits for physicians' services except those rendered by salaried staff of institutional providers such as hospitals; and (3) the requirement that Blue Shield participating physicians in most instances accept the Blue Shield payments as payment-in-full for services rendered to Blue Shield subscribers and not "balance bill" subscribers for additional amounts. Petitioners contended that the first two practices constituted a concerted refusal to deal and

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[2] A related case, *Grant V. Rodkey, et al.* v. *Blue Shield of Massachusetts, Inc., et al.*, United States District Court for the District of Massachusetts, No. 82-317-C, raising a claim for treble damages on account of the ban on balance billing and other alleged wrongs, remains pending.

an attempt to monopolize the market for prepaid health care by Blue Shield and Blue Cross, and that the third constituted illegal price-fixing by Blue Shield or was otherwise an unlawful contract in restraint of trade under § 1 of the Sherman Act.

Blue Shield and Blue Cross denied that these practices violated the federal antitrust laws, and further contended that all three were immune under the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341, 350-352 (1943), and its progeny, and exempt under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

This case has produced six reported opinions, including three by the Court of Appeals for the First Circuit, two by the District Court for the District of Massachusetts, and one by the Supreme Judicial Court of Massachusetts answering relevant questions of state law certified by the district court. These opinions, all of which bear the caption *Kartell* v. *Blue Shield of Massachusetts, Inc.*, are in chronological order: *Kartell I*, 592 F.2d 1191 (CA1 1979) (vacating and remanding judgment of dismissal on state action grounds); *Kartell II*, 384 Mass. 409, 425 N.E.2d 313 (1981) (RA1a-19a) (answering certified questions); *Kartell III*, 542 F.Supp. 782 (D. Mass. 1982) (RA20a-35a) (partial summary judgment for defendants); *Kartell IV*, 687 F.2d 543 (CA1 1982) (dismissing appeal from order denying intervenor-plaintiffs permission to raise new claims); *Kartell V*, 582 F.Supp. 734 (D. Mass. 1984) (PA28-68) (judgment enjoining Blue Shield from enforcing the ban on balance billing); and *Kartell VI*, 749 F.2d 922 (CA1 1984) (PA1-25) (reversing judgment enjoining the ban on balance billing; affirming remainder of judgment in favor of defendants).[3] The procedural history of this case and related cases is

[3] Citations in this brief to *Kartell II* and *Kartell III* are to the official reports and the corresponding pages in the appendix to this brief, cited "RA" followed by the page number. Citations in this brief to *Kartell V* and *Kartell VI* are to the official reports and the corresponding pages in the appendix to the petition in No. 84-1353, cited "PA" followed by the page number. Citations to *Kartell I* and *Kartell IV* are to the official reports only, neither opinion having been included in the appendix to either petition.

set out in detail in *Kartell IV*, 687 F.2d at 545-548, and *Kartell V*, 582 F.Supp. at 735-737 (PA29-32).

Following the decision of the Supreme Judicial Court in *Kartell II*, the district court on cross-motions for summary judgment held that Blue Shield's refusal to provide benefits for non-emergency services rendered by non-participating physicians in Massachusetts, and Blue Cross's refusal to provide benefits for physicians' services generally, are immune from antitrust challenge under the state action doctrine. *Kartell III*, 542 F.Supp. at 788-792 (RA26a-30a). However, the district court held that the ban on balance billing was neither immune under the state action doctrine (*id.*) nor exempt under the McCarran-Ferguson Act. *Id.* at 792-794 (RA30a-32a). It further held that the ban on balance billing was not a *per se* violation of § 1 of the Sherman Act (*id.* at 794-796 (RA32a-34a), but that it should be tested under the rule of reason. *Id.* at 796 (RA34a). After trial without jury, the district court ruled that the ban on balance billing was an unreasonable restraint of trade under § 1 of the Sherman Act and enjoined its further use by Blue Shield. *Kartell V*, 582 F.Supp. at 755 (PA67). In all other respects the case was dismissed. *Id.* at 755 (PA67, 72).

On appeal, the court of appeals (Campbell, Breyer and Cowen, JJ.), in a unanimous opinion by Breyer, J., reversed the district court's ruling that the ban on balance billing was unlawful, vacated the injunction enjoining its further use, and affirmed the district court's judgment dismissing the case in all other respects. *Kartell VI*, 749 F.2d at 934 (PA25).[4]

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[4] The court of appeals did not reach the issues of state action immunity or McCarran-Ferguson Act exemption for the ban on balance billing. However, these issues were fully tried and briefed at every level below. Accordingly, should this Court decide to review the judgment of the court of appeals, the judgment could be sustained on either of these grounds even though that court did not reach them. *United States* v. *New York Telephone Co.*, 434 U.S. 159, 166, n. 8 (1977). *Dandridge* v. *Williams*, 397 U.S. 471, 475-476, n. 6 (1970).

## II. Relevant Facts.

The history, development and current operation of the Blue Shield system are described generally in *Kartell II*, 384 Mass. at 414-418, 420-421, 423-425 (RA6a-10a, 12a-13a, 15a-17a). Blue Shield is the only medical service corporation organized under Mass. Gen. Laws c. 176B, and operates a non-profit medical service plan pursuant to that chapter. It is subject to comprehensive administrative regulation by the Commissioner, who must approve, *inter alia*, its subscriber contracts, subscriber rates, contracts with participating physicians and other providers and methods of compensating participating physicians and other providers. *Id.* at 422 (RA14a) (citing *Nelson* v. *Blue Shield of Massachusetts, Inc.*, 377 Mass. 746, 750, 387 N.E.2d 589, 592 (1979)).

Restrictions on balance billing have been an integral and important part of the Blue Shield system since its establishment in 1942. See *Kartell II*, 384 Mass. at 415-418 (RA7a-10a). Without such restrictions or their functional equivalent, Blue Shield would be unable to carry out its statutory purpose of "furnishing medical services at low cost to members of the public who become subscribers . . . ." Mass. St. 1941, c. 306, preamble. These restrictions enable Blue Shield to provide "service" benefits for covered medical services. In essence, service benefits are full benefits except for such limited deductibles or co-payments as may be specified in the subscriber contract.

To both carry out its statutory purpose and meet the demand of consumers and employers for full benefits for a broad range of medical services, Blue Shield contracts with physicians and other providers to pay them for covered services rendered to Blue Shield subscribers and covered dependents (collectively "members"). Under these contracts, participating providers agree to accept Blue Shield payments as payment-in-full and

not to try to collect additional payments directly from Blue Shield members.[5] This prohibition of additional charges is the "ban on balance billing" to which the petitioners object.

What the petitioners want is the right to collect an additional $100 million annually from Blue Shield members. They demand this right notwithstanding that imperfections in the physicians' services market already allow them monopolistic power over their fees (see *infra*, p. 11), notwithstanding increases in their fees and incomes far exceeding those of comparable occupational groups (see Exs. 2309-2310; Tr. 1035-1036), and notwithstanding a relative oversupply of physicians in Massachusetts. See *Kartell VI*, 749 F.2d at 927 (PA10-11). All that Blue Shield has done is to set its own buying prices for the services that it purchases on behalf of its members. It is conceded that Blue Shield has not entered into any form of horizontal agreement on price or otherwise. *Kartell VI*, 749 F.2d at 932 (PA21).

Since 1968, with the express approval of the Commissioner, Blue Shield payments to physicians have generally been determined by a formula or methodology known as the "usual and customary charge" system. *Kartell V*, 582 F.Supp. 740-741 (PA37-39). Briefly stated, paying usual and customary charges means paying a participating physician his or her usual charge for a service, except as that charge exceeds the customary charge for the service by physicians of similar training and experience in the same area.[6] The method was adapted from

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[5] Similarly, health maintenance organizations, independent practice associations and preferred provider organizations enter into agreements with physicians requiring them to accept payments from the plan as payment-in-full and to refrain from billing covered individuals for any difference between the physician's charge and the plan's allowance or payment. *Kartell VI*, 749 F.2d at 928-929 (PA14).

[6] The allowable charge for a service is the lesser of the physician's submitted charge, his or her usual charge for the service (the "level 1" charge) or the

and is similar to the prevailing charge method used under Medicare — Part B, which had been introduced in 1966. 42 U.S.C. § 1395j *et seq.*

In 1977, the Commissioner approved modifications to the usual and customary charge system which allowed Blue Shield to set maximum allowable percentage increases for both usual and customary charges, and limited the allowable percentage increase for customary charges to a percentage no greater than the percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers, Boston, All Items, less the medical care component thereof.

As to participating physicians and other participating providers, the ban on balance billing has been regularly and consistently enforced by a special administrative board established under Mass. Gen. Laws c. 176B, § 12, consisting of the Commissioner, the Attorney General and the Chairman of the Board of Registration in Medicine, or their designees (Exs. 815-854). It has also been enforced by the Attorney General under Mass. Gen. Laws c. 93A, which prohibits unfair and deceptive trade practices (Ex. 1167). In 1976 and 1977, the Commissioner twice refused to approve any relaxation of the ban on balance billing (Exs. 638-639, 648-649). In 1984, less than four months after the district court decision purporting to invalidate it, the ban on balance billing was made an express state statutory prohibition by act of the Massachusetts Legislature. See *infra*, pp. 17-18.

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applicable customary charge (the "level 2" charge). A physician's usual or level 1 charge was originally defined as the median of his or her reported charges submitted to Blue Shield during the applicable charge-reporting period. The customary or level 2 charge was originally defined as the 90th percentile of the usual charges for the service by established physicians within the same specialty and geographic area during the applicable charge-reporting period. Today, both usual and customary charges are subject to further limitations as described below.

Notwithstanding that over one-half of all Massachusetts residents are Blue Shield members, Blue Shield payments subject to the ban on balance billing account for only about 14 percent of total physicians' revenues in Massachusetts. *Kartell VI*, 749 F.2d at 924 (PA4). For services subject to the ban, the aggregate difference between submitted charges by participating physicians and Blue Shield payments to them was $69 million in 1979, $73 million in 1980, $81 million in 1981, $94 million in 1982, and was projected to be $103 million in 1983. *Kartell V*, 582 F.Supp. at 741 (PA39). Expressed as a percentage of submitted charges, these differences rose from 18.4 percent in 1976 to 30.7 percent in 1981, and have remained near the 30 percent figure since 1981. *Id.* If the ban on balance billing were eliminated, Blue Shield's subscribers would become liable for these amounts, either directly through additional charges by participating physicians or indirectly through the higher subscriber rates which Blue Shield would have to charge in order to pay full submitted charges to participating physicians.

## Summary of Argument.

Certiorari should not be granted for two basic reasons: (1) the decision of the court of appeals in this case represents a well-reasoned application of "mainstream antitrust doctrine" fully supported by prior decisions of this Court, the decisions of four other courts of appeals and several district courts in similar cases, and the weight of scholarly authority (pp. 10-17); and (2) the ban on balance billing, having been enacted as a state statutory prohibition following the decision of the district court in this case, is now immune from antitrust scrutiny, thus depriving this case of any significance for the future (pp. 17-18).

## Argument.

### I. The Decision of the Court of Appeals Is in Accordance with Similar Decisions of This Court, Four Other Courts of Appeals, and the Weight of Scholarly Comment.

Section 1 of the Sherman Act states that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. Simple contracts for the purchase and sale of goods or services, however, have never been considered "contract[s] . . . in restraint of trade" within the meaning of § 1 because they do no more than set the price and other terms of the transaction at hand. As the Seventh Circuit stated in *Quality Auto Body* v. *Allstate Insurance Co.*, 660 F.2d 1195, 1203 (CA7 1981), *cert. denied*, 455 U.S. 1020, 1023 (1982):

> A contract of this nature between a buyer (the insurance company) and a seller (the body shop) generally does not, without more, appear to violate the antitrust laws at all. Only if such an agreement contains restrictions on the party's activities *other than those involved in the immediate purchase and sale does* the possibility of a Sherman Act violation arise. [Emphasis by the court.]

Accord, *Proctor* v. *State Farm Mutual Insurance Co.*, 675 F.2d 308 (CADC 1982) *cert. denied*, 459 U.S. 839 (1982). See *Sitkin Smelting and Refining Co.* v. *FMC Corp.*, 575 F.2d 440, 446 (CA3 1978), *cert. denied*, 439 U.S. 866 (1978); *Mulhearn* v. *Rose-Neath Funeral Home, Inc.*, 512 F.Supp. 747, 753-754 (W.D. La. 1981) (funeral service insurance pol-

icy setting the amount to be paid for the service is not an antitrust violation because "to agree upon a price with a customer in the absence of other circumstance is not within the legal prohibition").

In *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 214 (1979), this Court described contracts providing for direct payments by Blue Shield of Texas to participating pharmacies for drugs provided to subscribers as "arrangements for the purchase of goods and services by Blue Shield." Because of the purchaser-seller relationship between Blue Shield plans and their participating providers, the courts of appeals in four circuits in addition to the First Circuit have held that a ban on balance billing does not violate the antitrust laws. *Pennsylvania Dental Association* v. *Medical Service Association of Pennsylvania*, 745 F.2d 248, 256-257, 259 (CA3 1984), *pet. for cert. filed*, 53 U.S.L.W. 3619 (No. 84-1296, February 13, 1985). *Royal Drug Co.* v. *Group Life & Health Insurance Co.*, 737 F.2d 1433, 1437-1438 (CA5 1984), *cert. denied*, 105 S.Ct. 912 (1985). *Sausalito Pharmacy, Inc.* v. *Blue Shield of California*, 677 F.2d 47 (CA9 1982) (*per curiam*) (affirming 544 F.Supp. 230 (N.D. Cal. 1981)), *cert. denied*, 459 U.S. 1016 (1982).[7] *Medical Arts Pharmacy of Stamford, Inc.* v. *Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (CA2 1982) (*per curiam*) (affirming 518

[7] In *Sausalito*, the plaintiff pharmacies alleged that § 1 of the Sherman Act was violated by provisions in Blue Shield's contracts prohibiting participating pharmacies from charging Blue Shield subscribers more than a specified amount — the so-called "deductible" — for covered drugs. The district court concluded that "contracts between purchasers and sellers do not impermissibly restrain trade unless there is some effect on price formation other than the terms of the contract itself." *Sausalito*, *supra*, 544 F.Supp. at 237 (citing *Blue Cross & Blue Shield* v. *Michigan Association of Psychotherapy Clinics*, *infra*). Because there was no such effect on price formation, the court granted Blue Shield's motion for summary judgment. The Ninth Circuit affirmed on the basis of the district court's opinion. *Sausalito*, *supra*, 577 F.2d at 48.

F.Supp. 1100 (D. Conn. 1981)).[8] Several district courts have held similarly on motions to dismiss or for summary judgment. *Davidowitz* v. *San Diego County Dental Society*, 1983-1 Trade Cases (CCH) ¶ 65,231 (S.D. Cal. 1983). *Michigan State Podiatry Association* v. *Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cases (CCH) ¶ 64,801 (E.D. Mich. 1982). *Feldman* v. *Health Care Service Corp.*, 562 F.Supp. 941 (N.D. Ill. 1982). *Blue Cross & Blue Shield of Michigan* v. *Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cases (CCH) ¶ 63,351 (E.D. Mich. 1980).

There are no cases to the contrary. Indeed, as one court noted:

> [E]ach federal court which has examined the question in the context of the antitrust laws has decided that an insurer paying out pursuant to its policy of insurance is actually a purchaser of goods or services, and that the insured is merely the recipient of the goods or services pursuant to the policy.

*Feldman* v. *Health Care Service Corp. supra*, 562 F.Supp. at 947 (citing *Sausalito, supra, Medical Arts, supra, Quality Auto Body, supra, Proctor, supra*, and *Michigan Association of Psychotherapy Clinics, supra*). Furthermore, as the court of appeals in this case observed, "scholarly commentators believe that these cases were correctly decided." *Kartell VI*, 749

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[8] In *Medical Arts*, Blue Cross Blue Shield provided for a "maximum billable amount" method of reimbursement under which it determined the maximum amount it would pay participating pharmacies for any drug. The court considered whether the provider agreement affected the prices for prescription drugs sold to non-Blue Cross Blue Shield customers, prices for non-drug items, or prices charged by non-participating pharmacies. Since there were no effects on parties or items apart from the contract terms themselves, the Second Circuit upheld summary judgment for Blue Cross Blue Shield. *Medical Arts, supra*, 675 F.2d at 506-507.

F.2d at 926 (PA9) (citing P. Areeda, *Antitrust Analysis*, pp. 530-531 (1981) ("[I]t is difficult to see what could make [such an] arrangement anticompetitive.")). Accordingly, there is no basis for granting certiorari. See Rule 17.1. Far from being in conflict, the courts of appeals in five circuits, taking their lead from this Court's decision in *Group Life & Health Insurance Co.* v. *Royal Drug*, *supra*, 440 U.S. at 214, are in agreement that a Blue Shield plan should, for purposes of applying the antitrust laws, be characterized or treated as a purchaser *vis-a-vis* its participating providers.

Strictly speaking, as the petitioners correctly point out, the courts in both *Sausalito* and *Medical Arts* held that the provider agreements at issue did not violate § 1 of the Sherman Act because they were not unreasonable restraints of trade, not because they were not restraints of trade at all. In this connection, the courts recognized that the agreements were not horizontal price-fixing, resale price maintenance or any other traditional type of *per se* violation. *Sausalito*, *supra*, 544 F.Supp. at 234. *Medical Arts*, *supra*, 675 F.2d at 505-506, and 518 F.Supp. at 1106-1107. Nevertheless, they then went on to analyze whether the agreements were unreasonable vertical restraints of trade notwithstanding that they merely set the price for the transactions at issue. In the present case, the court of appeals recognized that this sort of additional analysis was unnecessary because § 1 of the Sherman Act is not concerned with the reasonableness of a price agreed to by a purchaser and a seller unless that price is predatory or below incremental cost. *Kartell VI*, 749 F.2d at 927-928 (PA12-13). Otherwise, every purchase and sale contract could be challenged as an unreasonable restraint of trade, and the courts could become involved in determining the reasonableness of the agreed price for almost any transaction affecting interstate commerce. See *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 398 (1927) ("[W]e should hesitate to adopt a construction making

the difference between legal and illegal conduct in the field of business relations depend upon so uncertain a test as whether prices are reasonable . . .").

In an effort to distinguish this case, petitioners emphasize Blue Shield's alleged market power as a buyer in the physicians' services market. But, as the court of appeals pointed out, absent predatory or below cost pricing, "even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices." *Kartell VI*, 749 F.2d at 927 (PA12), and cases and authorities cited. Since there was no evidence of predatory pricing by Blue Shield (*id.* at 928 (PA13)), the court of appeals held that the ban on balance billing was lawful even assuming, which it did not decide, "that Blue Shield possesses significant market power . . . . [and] uses that power to obtain 'lower than competitive' prices." *Id.* at 927 (PA12).[9]

The petitioner's reliance on *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982), is misplaced. In *Maricopa*, the Court invalidated a horizontal agreement among competing physicians on their maximum charges to a prepaid

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[9] The court of appeals expressly recognized that "Blue Shield disputes the existence of significant 'market power" (*id.* at 926 (PA10)), noting that 99 per cent of Massachusetts physicians might participate whether Blue Shield had ten thousand or several million subscribers, that the supply of physicians in Massachusetts had "'increased steadily during the past decade,'" and that the issue of market power was "hotly debated by the expert economists who testified at trial." *Id.* at 926-927 (PA10-11).

In this connection, the district court's finding that Massachusetts physicians are required to participate with Blue Shield as "a matter of economic necessity" (*Kartell V*, 582 F.Supp. at 748 (PA54)) confuses the effects of the ban on balance billing with the effects of Blue Shield's refusal to provide benefits for non-emergency services rendered in Massachusetts by non-participating physicians, which is immune from antitrust scrutiny under the state action doctrine. *Kartell III*, 542 F.Supp. at 788-792 (RA26a-30a). Any loss of revenue to the petitioners that results from non-participation is an economic consequence of this refusal, not the ban on balance billing.

health care plan organized and controlled by them. Recognizing the difference between the horizontal restraint at issue in *Maricopa* and the vertical relationship here, the court of appeals correctly held that "*Maricopa* is simply not on point." *Kartell VI*, 748 F.2d at 930 (PA18).

In fact, *Maricopa* strongly indicates that a ban on balance billing implemented by an insurer is lawful and pro-competitive.[10] The Court noted (457 U.S. at 352):

> It is true that a binding assurance of complete insurance coverage — as well as most of the respondents' potential for lower insurance premiums — can be obtained only if the insurer and the doctor agree in advance on the maximum fee that the doctor will accept as full payment for a particular service. [Footnote omitted.]

The Court then stressed that insurers could achieve the same result without horizontal agreements among providers (*id.* at 353):

> *[I]nsurers are capable not only of fixing maximum reimbursable prices but also of obtaining binding agreements with providers guaranteeing the insured full reimbursement of a participating provider's fee.* In light of these examples, it is not surprising that nothing in the record even arguably supports the conclusion that this type of insurance program could not function if the fee schedules were set in a different way [than by horizontal agreement among providers]. [Emphasis supplied.]

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[10] The Solicitor General's *amicus curiae* brief in *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1970), made the same point: provider agreements are legal, absent evidence of a horizontal conspiracy. See *Maricopa*, *supra*, 457 U.S. at 353, n. 26.

The Court's recent decision in *Jefferson Parish Hospital District No. 2* v. *Hyde*, 466 U.S. , 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984), confirms that the antitrust laws do not condemn agreements between insurers and providers setting the price of services rendered to insureds. In *Hyde*, the Court held that the *per se* rule against tying arrangements did not apply to an exclusive contract between a hospital and a group of anesthesiologists. The Court noted that the "prevalence of third-party payment for health care costs reduces price competition, and a lack of adequate information renders consumers unable to evaluate the quality of the medical care provided by competing hospitals." *Id.*, 80 L.Ed.2d at 22.[11] In this setting, the Court observed: "Insurance companies are the principal source of price restraint in the hospital industry; they place some limitations on the ability of hospitals to exploit their market power." *Id.*, 80 L.Ed.2d at 23, n. 47.

Finally, the petitioners erroneously suggest that the court of appeals decided "'to tolerate manifestly anticompetitive conduct'" in violation of accepted antitrust principles because of the lower prices and savings to consumers generated by the Blue Shield system. Petition in No. 1353, p. 16. In fact, the

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[11] In the present case, the economic experts agreed with this point. The petitioners' own expert testified (Tr. 744-745, 763-768, 771):

> We take the view that medical care is provided monopolistically. The monopoly does not arise from the usual [cause] of a small number of sellers; even reasonably small cities usually contain several hospitals and scores of physicians. The monopoly problem arises because of the extremely poor and costly information available to medical consumers. Since consumers are not well aware of price, attractiveness and quality for the many alternative sources of medical care, each provider has something of a 'captive market.' If he were to raise his price somewhat, some but not all of his customers would desert him. On the other hand, if he were to lower his price, he would gain some customers but not the large number required to induce competitive behavior.

court of appeals noted "three considerations [which] convince us to apply mainstream antitrust doctrine" and which "militate strongly here against any effort by an antitrust court to supervise the Blue Shield/physician price bargain." *Kartell VI*, 749 F.2d at 930 (PA18). These considerations were: (1) that the prices at issue were low prices rather than high ones; (2) that the area of medical costs is one of "great complexity where more than solely economic values are at stake" (*id.* at 931 (PA19)); and (3) that the Blue Shield system, including payments to participating physicians, is "supervised by state regulators." *Id.* However, the court of appeals emphasized (*id.*): "These general considerations do not dictate our result . . . . They do, however, counsel us *against departing from present law* or extending it to authorize increased judicial supervision of the buyer/seller price bargain." [Emphasis supplied.] Even the petitioners concede that "this Court has not specifically applied the rule of reason to the price terms of a purchase contract . . . ." Petition in No. 1353, p. 11. It is they, not the court of appeals, who would depart from present law and "'blaze new trails.'" *Kartell VI*, 749 F.2d at 931 (PA19) (quoting *Feldman* v. *Health Care Service Corp.*, *supra*, 562 F.Supp. at 946).

## II. Since the Ban on Balance Billing Is Now a State Statutory Prohibition, Further Review by This Court Is Unwarranted.

Within four months after the decision of the district court holding that the ban on balance billing violated § 1 of the Sherman Act, the Massachusetts Legislature enacted by unanimous vote a new statute making the ban a state statutory prohibition. Mass. St. 1984, c. 192, § 1 (see *supra*, p. 2). Passed with an emergency preamble, the new statute became

effective on the date of enactment, July 12, 1984. Whatever the status of ban on balance billing under the state action doctrine prior to that date (see *supra*, p. 5, n. 4), after that date it became immune from antitrust scrutiny under *Hoover* v. *Ronwin*, 467 U.S. , , 104 S.Ct. 1989, , 80 L.Ed.2d 590, 599 (1984) (conduct of state legislature *ipso facto* immune from antitrust challenge). Accordingly, the injunction granted by the district court could not be reinstated even if the court of appeals were wrong on the antitrust merits, which it was not.[12]

This Court should not grant certiorari to review a question which has been essentially resolved by a subsequent statute (*Cook* v. *Hudson*, 429 U.S. 165, 165-166 (1976)), or which, to the extent that it has significance for the future, arises under a new statute. *Triangle Improvement Council* v. *Ritchie*, 402 U.S. 497, 498-501 (1971) (opinion of Mr. Justice Harlan).

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[12] The court of appeals acknowledged "the claim that a recently enacted state law, Mass. St. 1984, ch. 192, § 1, renders the case moot by immunizing Blue Shield's 'balance billing ban' from the reach of the antitrust laws." *Kartell VI*, 749 F.2d at 924 (PA5). However, recognizing, *inter alia*, that "the new statute may not immunize the defendants from treble-damage liability for past conduct," the court of appeals considered it "simpler and more appropriate to proceed directly to the antitrust merits." *Id.* The reference to "treble-damage liability" was a reference to the pending action for damages by substantially the same plaintiffs in the district court. See *supra*, p. 3, n. 2. The court of appeals apparently thought that if it did not decide the antitrust merits in this case, involving only an injunction as to future use of the ban, it might well have to decide them later in the related case involving damages for use of the ban prior to the adoption of the new statute. In practical terms, therefore, all that is at issue if this Court grants certiorari is the extent of the preclusive effect of the court of appeals judgment in this case on the pending damage action.

**Conclusion.**

For the foregoing reasons, the petitions for certiorari should be denied.

Respectfully submitted,

DANIEL O. MAHONEY,
*Counsel of Record*,
PALMER & DODGE,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

REGINALD H. HOWE,
Suite 2200,
One Beacon Street,
Boston, Massachusetts 02108.
(617) 227-4400

Dated: March 25, 1985

## Appendix.

## Table of Contents.


Opinion below (Kartell II) 1a

Opinion below (Kartell III) 20a

Massachusetts General Laws

c. 176B, § 7 36a

Acts of 1984

c. 192 38a

# JAMES P. KARTELL & others[1] *vs.* BLUE SHIELD OF MASSACHUSETTS, INC. & others.[2]

Suffolk. May 7, 1981. — August 20, 1981.

Present: HENNESSEY, C.J., LIACOS, ABRAMS, & NOLAN, JJ.

*Medical Service Corporation. Administrative Law*, Primary jurisdiction. *Insurance*, Commissioner of Insurance.

In considering questions certified by a judge of the United States District Court for the District of Massachusetts in an action by certain physicians against Blue Shield of Massachusetts, Inc., and Blue Cross of Massachusetts, Inc., this court declined to invoke the doctrine of primary jurisdiction to refer the questions to the Commissioner of Insurance for his determination where the certified questions involved matters of law and the application of principles of statutory construction and presented no unresolved factual issues. [412-414]

There is nothing in the broadly stated purpose of G. L. c. 176B or in the comprehensive regulatory power of the Commissioner of Insurance under c. 176B from which may be inferred a State policy requiring, or authorizing the Commissioner to require, that physicians who have signed agreements for services to subscribers of Blue Shield of Massachusetts, Inc., accept the fee paid by Blue Shield as payment in full for covered services. [414-423]

General Laws c. 176B, § 7, precludes payments by Blue Shield of Massachusetts, Inc., to physicians who have not signed Participating Agreements with Blue Shield for services rendered to subscribers except in cases of emergency or when services are rendered outside the State. [423-425]

Blue Cross of Massachusetts, Inc., is not empowered under G. L. c. 176A to make payments to subscribers or physicians for physicians' services [426-427], although it is permitted by c. 32A, § 4, to contract with the Group Insurance Commission to make payments for such services rendered to State employees [427].

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[1] Kartell is joined by three other Massachusetts physicians as parties plaintiff.

[2] The second named defendant is Blue Cross of Massachusetts, Inc. The Commissioner of Insurance has intervened as a party defendant.

QUESTIONS OF LAW certified to the Supreme Judicial Court by the United States District Court for the District of Massachusetts.

*James van R. Springer* of the District of Columbia (*Stanley V. Ragalevsky* with him) for the plaintiffs.

*Daniel O. Mahoney* (*Reginald H. Howe* with him) for Blue Shield of Massachusetts & another.

*Paul W. Johnson*, Assistant Attorney General, for Commissioner of Insurance, intervener.

NOLAN, J. On January 16, 1981, a judge of the United States District Court for the District of Massachusetts certified to this court two questions relating to a private antitrust action now pending in the Federal court. The questions are as follows:

"1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the annexed Stipulation and (b) to refuse to make payment for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including such limitation of fees?

"2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?" For the reasons which follow, we answer question 1(a) and 2 in the negative. We answer question 1(b) in the affirmative.

I. *Background.*

The plaintiffs, four Massachusetts physicians, seek injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26 (1976), against certain practices of the defendants, Blue Shield of Massachusetts, Inc. (Blue Shield), and Blue Cross of Massachusetts, Inc. (Blue Cross), which are alleged to operate in restraint of trade in violation of §§ 1 and 2 of

the Sherman Act, 15 U.S.C. §§ 1 and 2 (1976). Specifically, the plaintiffs allege that a) by refusing to reimburse physicians who have not signed Participating Physician's Agreements with Blue Shield for services to subscribers, except in emergencies or for services rendered outside Massachusetts, and b) by requiring that participating physicians accept Blue Shield's reimbursement as payment in full in most cases, Blue Shield is engaged in unlawful price setting. The plaintiffs further allege that Blue Cross has conspired with Blue Shield in refusing to provide benefits for physicians' services other than those rendered by the salaried staff of institutional providers such as hospitals and those rendered under Blue Cross's contract covering State employees, thereby perpetuating Blue Shield's alleged dominance in the market for physicians' services.

The defendants raised the defense that the challenged practices are immune from Federal antitrust attack under the "state action" exemption recognized in *Parker* v. *Brown*, 317 U.S. 341 (1943), and most recently articulated in *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). This contention was supported by the Commissioner of Insurance (Commissioner) and initially accepted by the trial judge, who in August, 1978, ordered the complaint dismissed. On appeal, however, the United States Court of Appeals for the First Circuit reversed, holding that the questions of statutory construction raised by the State action defense should initially be determined by the State courts. *Kartell* v. *Blue Shield of Mass., Inc.*, 592 F.2d 1191 (1st Cir. 1979). The Court of Appeals accordingly directed the District Court to abstain pending our decision in *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746 (1979), and, if sufficient guidance was not provided by that decision, to consider certifying questions to this court. *Kartell* v. *Blue Shield of Mass., Inc.*, *supra* at 1195. After determining that the *Nelson* decision did not speak to the central statutory issues raised by the instant case, the trial judge proceeded with this certification. The materials before us include the briefs

of the parties, including the Commissioner, a stipulation of facts accompanied by a documentary appendix, and certain materials developed during the discovery phase of the Federal litigation.

II. *Primary Jurisdiction.*

As a threshold matter, the defendants invoke the doctrine of primary jurisdiction, and urge that we refer both certified questions to the Commissioner of Insurance for his formal consideration. We decline to do so.

The doctrine of primary jurisdiction permits a court to refrain from exercising its jurisdiction until an administrative agency has determined some question or some aspect of a question arising in the proceeding before that court. 3 K.C. Davis, Administrative Law § 19.01, at 3 (1958). See *Murphy* v. *Administrator of the Div. of Personnel Administration*, 377 Mass. 217, 220-222 (1979). A court will apply the doctrine to promote uniformity of regulation and to take advantage of an agency's special expertise. *Mashpee Tribe* v. *New Seabury Corp.*, 592 F.2d 575, 580 (1st Cir. 1979). See *Nader* v. *Allegheny Airlines, Inc.*, 426 U.S. 290, 303-304 (1976). In antitrust cases, the doctrine of primary jurisdiction may provide a means of accommodating Federal antitrust policy to an agency's regulatory policy. 3 K.C. Davis, Administrative Law § 19.05, at 26 (1958). See *Ricci* v. *Chicago Mercantile Exchange*, 409 U.S. 289 (1973); Jaffe, Primary Jurisdiction, 77 Harv. L. Rev. 1037, 1069-1070 (1964). Its use in a given case, however, rests in the sound discretion of the trial judge. *Lehman Bros.* v. *Schein*, 416 U.S. 386, 391 (1974).

In the instant case, the judge who certified questions of law to this court has already considered the applicability of the doctrine of primary jurisdiction. He rejected the defendants' comparison of the allegations in this case with those in *Nelson* v. *Blue Shield of Mass., Inc., supra*, where we applied the doctrine to dismiss a complaint alleging that certain of Blue Shield's practices, regulated by the Commissioner, violated State law provisions which are enforced in the first instance by the Commissioner. The judge con-

cluded that in the instant case "[t]he threshold question . . . is purely one of state statutory construction; no fact-finding, administrative proceedings are necessary or even relevant." Because we agree with the statement, we need not reach the question whether, under our Uniform Certification of Questions of Law rule, S.J.C. Rule 1:03, as appearing in 382 Mass. 700 (1981), we possess the power to refer certified questions to an agency for its consideration, especially when the Federal trial court has already refused to do so. See *SDK Medical Computer Servs. Corp.* v. *Professional Operating Management Group, Inc.*, 371 Mass. 117, 126-127 (1976), which held that, although it is possible that certain charges as to unfair competitive practices by Blue Shield should be initially referred to the Commissioner of Insurance for correction under his administrative authority, the matter is one for consideration by the trial court. But see *Kartell* v. *Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1196 (1st Cir. 1979) (Coffin, C.J., dubitante) ("[I]f, in the process of considering the questions certified the Massachusetts court finds the record to be inadequate, I would see no reason why it could not require the record to be supplemented as might be necessary").

We find the first rationale supporting primary jurisdiction — the promotion of uniformity and consistency in the regulation of business entrusted to a particular agency — to be unimportant here. The danger of inconsistency present where, for example, various Federal courts construe the provisions of Federal regulatory statutes, is absent in our construction of State law as it applies to a State agency.[3] See Comment, Confusion of Exhaustion of Administrative

[3] In this regard, we note that courts disagree on the question whether referral from a Federal court to a State agency under the primary jurisdiction doctrine is ever appropriate in State action analysis. Contrast *Litton Sys., Inc.* v. *Southwestern Bell Tel. Co.*, 539 F.2d 418, 421 (5th Cir. 1976), with *Industrial Communications Sys., Inc.* v. *Pacific Tel. & Tel. Co.*, 505 F.2d 152 (9th Cir. 1974). See Note, *Parker* v. *Brown* Revisited: The State Action Doctrine Under Goldfarb, Cantor, and Bates, 77 Colum. L. Rev. 898, 925-928 (1977).

Remedies and Primary Jurisdiction Doctrines, 7 Suffolk U.L.Rev. 124, 138-139 (1972).

As to the second rationale supporting the use of primary jurisdiction — reliance on an agency's special expertise, especially with respect to issues involving technical questions of fact — we perceive no lack in the voluminous record before us which could be remedied by any kind of administrative proceeding. The certified questions before us involve questions of law and the application of principles of statutory construction. We agree with the District Court that, in this regard, *Nelson* v. *Blue Shield of Mass., Inc.*, *supra*, is distinguishable. That case involved, among other questions, consideration of the frequency with which Blue Shield's board had been convened, the adequacy of its staff, its technical competence, and the efficiency of its procedures. *Id.* at 753. Such factual questions underlay what amounted to "an attack on the entire system by which Blue Shield compensates participating physicians." *Id.* The certified questions before us, while potentially having a broad impact on the Blue Cross-Blue Shield insurance system, present no such unresolved issues of fact, nor do they involve any claimed violation of the statutes administered by the Commissioner. Accordingly, we see no need to refer to the Commissioner any aspect of the questions certified.

III. *Restriction on "Balance Billing."*

The parties have stipulated that, at present, approximately 96 per cent of all Blue Shield subscribers are covered by "service benefit" contracts, under which a participating physician is required to accept the fee paid by Blue Shield as payment in full for covered services. Thus, only about 4 per cent of subscribers may be billed directly by participating physicians for amounts in addition to Blue Shield's approved rate, or "balance billed", as the plaintiffs term it. The defendants, conceding that no provision of G. L. c. 176B specifically orders this restriction, argue that the statutory purpose of providing low cost medical care, coupled with the Commissioner's regulatory actions in furtherance of that purpose, are together sufficient to insulate the restriction

from Federal antitrust attack. We disagree. Assuming, as we must, that the challenged practice operates to restrain competition in contravention of Federal antitrust law, we find in G. L. c. 176B no affirmative policy requiring, or authorizing the Commissioner to require, such a restraint. We therefore answer question 1(a) in the negative.

The restriction on balance billing is a product of two features of the Blue Shield system. Under the Participating Physician's Agreement presently in use, participating physicians are contractually obligated to accept Blue Shield's fees as payment in full for services rendered to members who are covered by service benefit, as opposed to indemnity benefit, contracts. Historically, as is explained in greater detail later in this opinion, service benefits were available only to subscribers who came within approved income limits. With the advent in 1968 of the "usual and customary charge" method of compensation, however, service benefits were for the first time provided to many subscribers without regard to their income. This development is the focal point of the State action controversy, and we explore it in some detail below.

Blue Shield was incorporated on May 6, 1942, under the name Massachusetts Medical Service. It was the first and remains the only medical service corporation organized under G. L. c. 176B. On September 18, 1942, the Commissioner gave his approval to the first subscription contract, Participating Physician's Agreement, schedule of rates to be charged subscribers, and schedule of fees to be paid participating physicians. The Participating Physician's Agreement, which remains unchanged to the present day, provides that "[t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the fee schedule in effect at the time the services are rendered."

The original subscription certificate established two classes of subscribers, "limited" and "unlimited". An unlimited subscriber was one whose annual income was less than a certain amount on file with the Commissioner, a limited subscriber was one whose income exceeded that amount. Income limits were reviewed periodically, and revised to reflect general increases in wages. In 1951, Blue Shield implemented a second plan, known as Plan "B", to supplement the original plan, which was known as Plan "A". Under Plan "B", a single income limit of $5,000 was set for the subscriber and covered dependents; Plan "A" retained separate limits of $2,000 for an individual, $2,500 for families of two, and $3,000 for families of three or more. Plan "B" imposed higher subscription rates and paid higher fees for doctors; essentially, it provided the option of more comprehensive coverage, particularly for higher income subscribers, but did not otherwise depart from the basic precedent of Plan "A".

In 1956, Blue Shield and Blue Cross jointly initiated the Master Medical Certificate, providing comprehensive coverage of hospital and medical costs under a single plan. As with Plan "B", however, there was no departure from the income limit method of determining a subscriber's entitlement to service benefits.

By the late 1960's, there was pervasive dissatisfaction among participating phsyicians with Blue Shield's fees, and particularly with fees received under service benefit contracts. See, e.g., Proceedings of the Massachusetts Medical Society, May 16, 1967. In response to the complaints of participating physicians, Blue Shield in late 1967 or early 1968 filed with the Commissioner a proposed revision of the Master Medical Certificate accompanied by a proposed "Amended Schedule of Benefits — Blue Shield Portion of the Blue Cross — Blue Shield Master Medical Certificate" (1968 Amended Schedule of Benefits). This filing introduced the usual and customary charge method of compensation. Blue Shield proposed to substitute for fixed fee schedules a system under which participating physicians

would receive 95 per cent of the lesser of their usual charge, or the customary charge, for a particular service. The usual charge is calculated by determining the median of all fees charged by a particular physician for a specific service during each six-month reporting period. Similarly, the customary charge is established as the mean of all fees reported for a particular service by physicians of like experience and training during each reporting period.

The advantage to participating physicians in this method of calculating fees lay in the promise of higher fees immediately for many services and relatively automatic future adjustments for inflation. Its benefit to consumers was that, for the first time, participating physicians would be bound to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income. When the method was first proposed in 1968, it was to be implemented only for group accounts under the Master Medical Certificate and for Blue Shield's coverage of the Federal Employees program.[4] At present, however, it is applied to all Blue Shield accounts except the few remaining Plan "B" subscribers.

The revisions to the Master Medical Certificate and the 1968 Amended Schedule of Benefits were approved by the Commissioner effective February 1, 1968. From 1970 until 1975, Blue Shield updated usual and customary charges as it deemed appropriate without objection from the Commissioner. In 1976, Blue Shield deferred any update due primarily to a decrease in its reserves from $26 million to $1 million during the eighteen months preceding April 30, 1976. On March 1, 1977, the financial condition of the corporation having improved, Blue Shield filed an amended schedule of benefits. On April 15, 1977, the amended schedule of benefits was approved by the Commissioner subject to the condition that for the 1977 update, "the usual fees and the normal customary fees shall not exceed increases of 107%

[4]The parties offer no estimate of the percentage increase in service benefits at the time this method was instituted.

and 104% respectively, of those fees implemented in July, 1975."[5] In 1978, the Commissioner took the position that any update of usual and customary charges was subject to his prior written approval. A revision to the amended schedule of benefits was filed in 1978 and received preliminary approval, but, following a change in administrations, that approval was rescinded. Accordingly, the 1977 schedule of benefits has remained effective to the present.

The defendants argue that in exercising his power of approval over methods of compensation to achieve the statutory purpose of providing low cost medical care to the public, the Commissioner exerts sufficient control over Blue Shield that the present methods of compensation, and the concomitant limitations on physicians' fees, must be considered to be compelled by a "clearly articulated and affirmatively expressed state policy." There is no simple definition of the degree of State compulsion which will suffice to constitute State action for antitrust purposes. Several of the United States Supreme Court's decisions in which such a policy was found dealt with State schemes with an avowed purpose to restrain competition. See, e.g., *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97 (1980); *Bates* v. *State Bar*, 433 U.S. 350 (1977); *Parker* v. *Brown*, 317 U.S. 341 (1943). In this case, however, we are asked to infer such a policy from the broadly stated purpose of G. L. c. 176B and the comprehensive regulatory power of the Commissioner under the statute.

The Supreme Court dealt with an analogous, although not identical, contention in *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976). There, a retail pharmacist engaged in marketing light bulbs brought suit to enjoin an electric utili-

[5] The 1977 amended schedule of benefits was later challenged in a proceeding instituted by several physicians and the Massachusetts Medical Society. The suit was ultimately dismissed on the ground that the plaintiffs had failed to exhaust their administrative remedies. See *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746 (1979).

ty company from distributing to its customers, with no separate charge, approximately fifty per cent of the most commonly used light bulbs. The cost to the utility of maintaining this program was approved by the State public utility commission as one aspect of the tariffs filed by the utility.

The Court formulated the issue tendered in terms of whether "the *Parker* rationale immunizes private action which has been approved by a State and which must be continued while the state approval remains effective." *Id.* at 581. Reversing the United States Court of Appeals for the Sixth Circuit, the Court held that the State's regulatory approval was insufficient to invoke the *Parker* immunity. In its analysis of the case, the Court offered two possible rationales for holding private conduct immune from Federal antitrust attack. First, it noted the potential injustice of holding a private actor liable for simply "[obeying] the command of his state sovereign"; second, the Court suggested that "if the State is already regulating an area of the economy, it is arguable that Congress did not intend to superimpose the antitrust laws as an additional, and perhaps conflicting, regulatory mechanism." *Id.* at 592.

The Court then noted that where the option to initiate the challenged program lay primarily in the private actor's hands, there was no inherent injustice in requiring that the utility conform its conduct to Federal law. *Id.* at 594. Second, and perhaps of more significance to the instant case, the Court found "no logical inconsistency between requiring [the utility] to meet [State] regulatory criteria in so far as it is exercising its natural monopoly powers and also to comply with antitrust standards to the extent that it engages in business activity in competitive areas of the economy." *Id.* at 596. Thus, where the State's regulatory interest could not be considered to extend to the market in light bulbs, the possibility of Federal and State policy conflict was absent. *Id.* at 584-585, 596; see *Bates* v. *State Bar, supra* at 361; *Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389, 419 (1978) (emphasizing the importance of a clearly and affirmatively expressed State policy "requiring the anti-

competitive restraint as part of a comprehensive regulatory system").

In deciding whether Blue Shield's current methods of compensation are compelled by State policy, we understand that we are to look to at least the following factors: any indication that in enacting G. L. c. 176B the Legislature sought to restrain competition in the market for physicians' services; the nature of and extent of the Commissioner's regulatory powers; and the degree to which any State interests involved could be accommodated by a method of compensation with a lesser effect on competition. See, e.g., *Sound, Inc.* v. *American Tel. & Tel. Co.*, 631 F.2d 1324, 1334 (8th Cir. 1980); *George R. Whitten, Jr., Inc.* v. *Paddock Pool Builders, Inc.*, 424 F.2d 25, 30 (1st Cir. 1970). We conclude that, under this analysis, Blue Shield's current method of compensation is not required by any express State policy.

First, to the extent that the Legislature, in enacting G. L. c. 176B, was concerned at all with the market in physicians' services, that concern appears to have been limited to providing a means whereby persons of average and low income could obtain otherwise unaffordable medical care. The clearest indication of this limited purpose is the fact that for the first twenty-six years of its operation, Blue Shield limited service benefits, with the Commissioner's approval, to subscribers who met certain income requirements. It is apparent that neither Blue Shield nor the Commissioner during this period believed that G. L. c. 176B required the extension of service benefits beyond this population.

This limited view of the purpose of G. L. c. 176B is supported by other materials which, while they do not constitute formal legislative history, nevertheless shed light on the contemporary understanding of the Blue Shield program. We have previously relied on such materials in determining legislative intent. See *Pereira* v. *New England LNG Co.*, 364 Mass. 109, 115 (1973).

The draft legislation which was enacted as G. L. c. 176B was introduced by the Massachusetts Medical Society. After

its introduction, the Medical Society observed in its official journal that the legislation was "submitted as evidence of a sincere effort on the part of the Massachusetts Medical Society to meet the present-day problems of low-income groups in regard to paying for medical care." Medical Service Corporations, 224 New England J. Med., No. 3, 124 (1941). In 1962, the Legislature empanelled a "Special Commission to Investigate and Study the Laws relative to Non-Profit Hospital and Medical Service Corporations, and the Rising Cost of Hospital and Medical Care and Hospital Accommodations" (Special Commission); the Special Commission's Final Report was filed in 1964. See 1964 Senate Doc. No. 958. The Special Commission specifically noted that both service and indemnity benefits were contemplated under G. L. c. 176B, and linked the provision of service benefits to Blue Shield's corporate purpose. "Simply stated, the fundamental purpose of . . . Blue Shield is to make available at the lowest possible premium cost, to the average and below average income citizen . . . a plan whereby the medical and surgical needs of himself and his family would be paid for in full at the time of such need." *Id.* at 142. See also *id.* at 182 (recommending that "the service-benefit features of Blue Shield contracts be retained in order to retain its purpose of serving the average and below average income subscribers"). While the Special Commission's report cannot be taken as an indication of original legislative intent, it does reflect the contemporary understanding of the underlying purposes of Blue Shield. The conclusion is inescapable that no one familiar with the legislative scheme, either at its inception or immediately prior to the adoption of the present method of compensation, believed that it required the near universal provision of service benefits which is now subject to challenge.

The second dimension to the defendants' State action argument is that G. L. c. 176B gives the Commissioner pervasive regulatory powers over Blue Shield, and that since 1968 he has exercised those powers to compel the extension of service benefits at their present level. Our review of the

Commissioner's powers convinces us that his approval of the usual and customary method of compensation does not constitute State action for the purposes of antitrust immunity. In *Nelson* v. *Blue Shield of Mass., Inc.*, 377 Mass. 746, 750 (1979), we held that "G. L. c. 176B establishes a comprehensive scheme for the public supervision of medical service corporations." In support of this conclusion, we noted the Commissioner's power of approval over Blue Shield's articles of organization (§ 2), by-laws (§ 3), "the form of its agreements with participating providers and its methods of compensating them (§ 4)," as well as the certificates issued to, and the rates charged, subscribers (§§ 4, 6). *Id.*

By G. L. c. 176B, § 4, the Commissioner is specifically required to approve in writing Blue Shield's "methods of compensating" providers. This language was inserted by St. 1968, c. 432, § 9; prior to this amendment, § 4 required the Commissioner to approve Blue Shield's "rates" of compensation. Under the prior law, we noted that because physician fee schedules are the primary determinants of the rates charged to Blue Shield's subscribers, the express standards governing the Commissioner's approval of rates to subscribers "are implicitly the standards to be applied by the Commissioner . . . in determining the rates at which the physicians are to be compensated. . . . It follows that the Commissioner may disapprove the fee schedule only if the fees are inadequate, excessive or unfairly discriminatory." *Massachusetts Medical Serv.* v. *Commissioner of Ins.*, 344 Mass. 335, 338-339 (1962). There is no reason to think that the substitution, in 1968, of the word "methods" for the word "rates" implied any change in the Commissioner's role under § 4. Thus, following our analysis in *Massachusetts Medical Serv.* v. *Commissioner of Ins.*, *supra* at 339, we think that the present § 4 does not give the Commissioner power to establish Blue Shield's methods of compensation, but only to disapprove them if they are outside the "range of reasonableness." Cf. *Hathaway* v. *Commissioner of Ins.*, 379 Mass. 551, 554 (1980). (St. 1968, c. 432, § 9, indicates no intention to have physicians' fees fixed by the Commissioner.)

The above analysis leads us to the conclusion that although the usual and customary charge method of compensation may represent a reasonable accommodation of the various interests involved in establishing Blue Shield's rates of reimbursement to participating physicians, it is only one among a range of methods that the Commissioner would be required to approve. At least to the extent that it goes beyond the statutory policy of providing service benefits to low income subscribers, it cannot be said to be required by the State. Cf. *Cantor* v. *Detroit Edison Co.*, *supra*, at 584-585.

IV. *Limitation on Payments to Nonparticipating Physicians.*

By contrast to question 1(a), question 1(b) involves a relatively straightforward process of statutory construction. We agree with the defendants that G. L. c. 176B, § 7, precludes payments by Blue Shield to nonparticipating physicians for services rendered to subscribers except in cases of emergency or for services rendered outside the State.

General Laws. c. 176B, § 7, as appearing in St. 1978, c. 574, § 3, provides in relevant part that "[*a*] *subscriber or a covered dependent*, subject to the by-laws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, *shall be entitled to the benefits of this chapter upon receiving medical . . . service from any participating physician . . . or*, in the discretion of the corporation, *upon receiving medical . . . service from any non-participating physician . . . in an emergency or when outside the commonwealth*" (emphasis added). A nonprofit medical service plan is defined by G. L. c. 176B, § 1, as "a plan operated by a medical service corporation . . . whereby the cost of medical . . . service . . . furnished to subscribers and covered dependents is paid by the corporation . . . to participating physicians . . . and to such other physicians as are provided for herein . . . ." Finally, a participating physician is defined as "a registered physician . . . who agrees in writing with a medical service

corporation to perform medical service for subscribers and covered dependents and to abide by the by-laws, rules and regulations of such corporation." G. L. c. 176B, § 1. These sections, read together, indicate a clear legislative purpose to limit the advantages of reimbursement by Blue Shield — principally the guarantee of prompt payment at a fixed rate — to those physicians who choose to participate in the program. The plaintiffs, however, suggest that § 7 merely limits the benefits to which subscribers are entitled, but in no way compels Blue Shield to refuse reimbursement to nonparticipating physicians for nonemergency services rendered in the State.

To the extent that the language of § 7 is ambiguous, the ambiguity is resolved by reference to the structure and history of the Blue Shield program as a whole. The critical language of § 7 was included in the initial bill submitted by the Medical Society to authorize the formation of nonprofit medical service corporations, as well as in the successor bill which was ultimately enacted as G. L. c. 176B. See 1941 House Doc. No. 1477, § 7; 1941 House Doc. No. 2301, § 7. The participating physician concept was integral to the original vision of the manner in which medical service plans would operate. Because medical service corporations were to be formed and operated by the medical profession itself, rather than by commercial insurance companies, the drafters of the enabling legislation were faced with the problem of either accumulating the financial reserves required to guarantee the soundness of the program, or finding some acceptable substitute. This problem was addressed by means of the "unit system," under which participating physicians themselves acted as underwriters of risk.

The system was presented to the Commissioner of Insurance, in a statement from the Medical Society, as a substitute for the reserve requirements of traditional insurance plans. The Medical Society's statement to the Commissioner argued that the unit system "constitutes an actuarial substitute for the necessary large financial reserves

of profit-making commercial corporations . . . . This is necessary in commercial corporations because [financial demands] are directly related to contractually binding, inflexible indemnity schedules. *Thus there is substituted in Massachusetts Medical Service, Inc.* for such large financial reserves, *a guaranteed medical-service reserve* to the subscribers during the terms of the contract, *by participating physicians who accept an unguaranteed and fluctuating schedule of indemnification*, the current monetary equivalent of which at any time is determined by an equitable proration of available earned income among the participating physicians" (emphasis added).

The original Participating Physician's Agreement, approved by the Commissioner of Insurance on September 18, 1942, contained the following clause: "*Unit System*: In the event that the amount available in any accounting period for distribution to Participating Physicians . . . shall be insufficient to pay all Participating Physicians in full, then the amount which the Board of Directors decides is available for distribution shall be paid to all Participating Physicians on a pro rata basis." This agreement remains in use at present.

Obviously, the potential benefits to physicians stemming from participation in the plan were accompanied by an element of risk. Had physicians been free to obtain payment for services to subscribers without incurring the risk of reduced payment under the unit system, there would have been little incentive to participate. Against this background, we think it clear that the Legislature intended by G. L. c. 176B, § 7, to limit Blue Shield's system of reimbursement to participating physicians, except in those circumstances in which such services could not reasonably be obtained.

V. *Blue Cross's Authority to Contract for Payment for Physicians' Services.*

To respond to question No. 2 it will be helpful to recast the question into two questions: (a) Is Blue Cross empowered under G. L. c. 176A to cover physicians' services

under the caption "other health services" as that phrase is used in G. L. c. 176A, § 1? (b) By what authority is Blue Cross authorized to contract directly with the Commonwealth to cover services of physicians?

The first question (a) must be answered "no". Blue Cross was permitted to provide benefits only for hospital services until 1953. In that year the Legislature amended G. L. c. 176A, § 1, to permit a hospital service corporation to provide "reimbursement for other health services." St. 1953, c. 287, § 1. These "other health services" have included such nonhospital providers as visiting nurse associations, mental health clinics and home health agencies. Authorization for these contracts is found in the fourth paragraph of G. L. c. 176A, § 5.

It has been stipulated that Blue Cross has never provided benefits for physicians' services except (1) covered services rendered by salaried staff physicians of hospitals and certain other institutional providers with which it has contracts; and (2) nonemergency, in State service rendered by participating and nonparticipating Blue Shield physicians under the State employees' contract.

The Master Medical Certificate issued to subscribers provides that "[b]enefits contained herein for all services and supplies other than those furnished by a physician, dentist, podiatrist, or psychologist shall be provided by Blue Cross," and that "[b]enefits contained herein for services of a physician, dentist, podiatrist, or psychologist shall be provided by Blue Shield."

It is highly unlikely that the Legislature would authorize Blue Cross and Blue Shield to sail on a collision course of competition for subscribers for coverage of physicians' services when Blue Cross's principal course is directed toward hospital services and Blue Shield's towards physicians' services. Equally improbable is a legislative intent to permit Blue Cross to provide the benefits of a full range of physicians' services on a nonparticipating basis and thereby escape the network of regulation found in G. L. c. 176B. In

short, Blue Cross is not empowered to cover physicians' services except in those instances already noted.

The answer to the second question (b) can be found in G. L. c. 32A, § 4. Blue Cross is authorized to contract with State employees because the Legislature vested it with such authority. Under this statute,[6] the Group Insurance Commission is authorized to enter into an agreement for insurance coverage for State employees with Blue Cross "in the same manner as any other insurance company."

The authority for contracts with State employees reposes in G. L. c. 32A in the first instance, and not in G. L. c. 176A. The express reference to G. L. c. 176A in G. L. c. 32A, § 4, encourages us to rule that such provision is special and thus, absent a contrary legislative intent, it must prevail over conflicting provisions, if any, in G. L. c. 176A and c. 176B. See *Boston Teachers Local 66* v. *School Comm. of Boston*, 370 Mass. 455, 472 (1976). Accordingly, we respond to this question by recognizing that payments to physicians for medical services under the contract between Blue Cross and the Group Insurance Commission are authorized by the express language of G. L. c. 32A, § 4, and, as such, this coverage does not derogate from the exclusiveness of Blue Shield's coverage for physicians' services to subscribers who are not under the contract insuring State employees.

In conclusion, we answer question 1(a), "No", 1(b), "Yes", 2, "No".

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[6]The relevant paragraph of G. L. c. 32A, § 4, as amended through St. 1979, c. 268, § 2, is as follows: "For the purposes of this chapter, any savings bank authorized to engage in the insurance business in accordance with chapter one hundred and seventy-eight and any nonprofit hospital service corporation or nonprofit medical corporation organized under chapter one hundred and seventy-six A or one hundred and seventy-six B shall be and is hereby authorized to enter into a reinsurance agreement as herein provided in the same manner as any other insurance company."

James P. KARTELL, Plaintiff,

v.

BLUE SHIELD OF MASSACHUSETTS, Defendant.

Grant RODKEY, Plaintiff,

v.

BLUE CROSS OF MASSACHUSETTS, Defendant.

Civ. A. Nos. 78-0594-C, 82-0317-C.

United States District Court, D. Massachusetts.

June 30, 1982.

As Amended July 7, 1982.

Various parties moved for summary judgment in suit claiming that agreements between medical insurance plan and participating physicians violated antitrust law. The District Court, Caffrey, Chief Judge, held that state action doctrine barred certain claims but neither state action doctrine nor McCarran-Ferguson Act barred other claims.

Order accordingly.

**1. Physicians and Surgeons ⇐21**

No state law or policy requires either Commissioner of Insurance or medical insurance plan to prohibit physician from billing patient for fees not paid by medical insurance. M.G.L.A. c. 176B, §§ 3, 4, 7.

**2. Monopolies ⇐18**

Medical insurance plan's practice of prohibiting physicians from balance billing insured was not shielded from scrutiny under federal antitrust laws under state action doctrine. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

**3. Monopolies ⇐18**

Medical insurance plan's practice of restricting to participating physicians remuneration for services rendered to subscribers was clearly articulated and affirmatively expressed as state policy, and satisfied first part of state action test. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

**4. Monopolies ⇐18**

Where medical insurance plan's practice generally excluding nonparticipating physicians from remuneration was compelled by statute, it a fortiori passed second part of state action test and was immune from federal antitrust scrutiny under state action doctrine. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

**5. Monopolies ⇐18**

In view of explicit language of state statute excluding nonparticipating physicians from remuneration under medical insurance plan, court, in determining whether such practice was protected from antitrust scrutiny under state action doctrine, need not consider test relating to whether challenged restraint is necessary to successful operation of legislative scheme that state sovereign established. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176B, §§ 3, 4, 7.

**6. Monopolies ⇐18**

Hospital insurance plan's forbearance from generally providing benefits for physician's services was immune under state action doctrine from antitrust challenge. Clayton Act, § 16, 15 U.S.C.A. § 26; Sherman Anti-Trust Act, §§ 1, 2, 15 U.S.C.A. §§ 1, 2; M.G.L.A. c. 176A, § 1 et seq.

**7. Monopolies ⇐28(7.1)**

To establish that agreements between medical insurance plan and its participating physicians were within protection of McCarran-Ferguson Act, plan had burden of showing that agreements were the business of insurance, the agreements must be regulated by state law, and that any agreement to boycott, coerce or intimidate, or act of boycott, coercion, or intimidation was outside Act's exemptive powers and subject to

antitrust laws. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

**8. Monopolies ⇐18**

Where participating physicians in medical insurance plan agreed to be compensated for their services rendered to subscribers on pro rata basis if insurer was unable at any time to compensate participating physicians in full because of depletion of funds, there was some amount of risk placed on participating physicians for purpose of determining application of McCarran-Ferguson Act. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

**9. Monopolies ⇐18**

Fact that agreements between participating physicians and medical insurance plan required participating physicians to carry some risk was not sufficient to establish that agreements were business of insurance. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

**10. Monopolies ⇐18**

Even though agreements between participating physicians and medical insurance plan required physicians to assume some risk by agreeing to be compensated on pro rata basis if plan was unable to compensate in full because of depletion of funds, agreements did not constitute "business of insurance" so as to be exempt from antitrust regulation under McCarran-Ferguson Act. McCarran-Ferguson Act, §§ 1–5, 2(b), 15 U.S.C.A. §§ 1011–1015, 1012(b).

**11. Monopolies ⇐18**

Agreement whereby participating physicians in medical insurance plan were barred from balance billing subscribers did not rise to level of per se violation of Sherman Act. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

**12. Monopolies ⇐12(17)**

Per se prohibition of Sherman Act provision making unlawful any contract, combination, or conspiracy in restraint of trade or commerce applies as much to professional services as it does to commodities. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

**13. Monopolies ⇐18**

Agreements between medical insurance plan and participating physicians should be examined under traditional rules of reason standard to determine whether they violate Sherman Act provision making unlawful contracts, combinations, or conspiracies in restraint of trade or commerce. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

**14. Federal Civil Procedure ⇐2546**

Sufficient facts had not yet been developed to allow court to make proper determination, under rule of reason standard, of whether agreements between medical insurance plan and participating physicians violated Sherman Act prohibition of agreements in restraint of trade or commerce and motions for summary judgment will be denied and further discovery directed. Sherman Anti-Trust Act, § 1, 15 U.S.C.A. § 1.

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Stanley V. Ragalevsky, Warner & Stackpole, Boston, Mass., David I. Shapiro, Dickstein, Shapiro & Morin, Washington, D. C., for plaintiffs.

Thayer Fremont-Smith, Choate, Hall & Stewart, Boston, Mass., for intervenor-plaintiffs.

Reginald H. Howe, Daniel Mahoney, Palmer & Dodge, Boston, Mass., for Blue Cross and Blue Shield of Mass.

## OPINION

CAFFREY, Chief Judge.

This is a private civil antitrust action which was originally filed in March of 1978 by four Massachusetts physicians who request injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26, for alleged violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, by Blue Shield of Massachusetts, Inc. (Blue Shield) and Blue Cross of Massachusetts, Inc. (Blue Cross). The Massachusetts Commissioner of Insurance (the Commissioner) intervened as a party defendant, and by order of this Court entered on January 29, 1982, the Massachu-

setts Medical Society (the Society), Grant V. Rodkey and Henry Brown were permitted to intervene "as parties plaintiff in the existing complaint."

In accordance with the suggestion of the Court of Appeals for this Circuit (*Kartell v. Blue Shield of Massachusetts*, 592 F.2d 1191, 1195 (1st Cir. 1979)), in January 1981 the Honorable Walter Jay Skinner of this Court certified certain questions of state law to the Supreme Judicial Court of Massachusetts on a record consisting principally of a Stipulation of Facts and related Exhibits. At that time, Judge Skinner, to whom this case was then assigned, stated that upon his receiving answers to the certified questions, the defendants' pending motion to dismiss would then be treated as a motion for summary judgment to be heard and determined on the same record as the certified questions. In an opinion filed on August 20, 1981, the Supreme Judicial Court answered the certified questions, *Kartell v. Blue Shield of Massachusetts, Inc.*, — Mass. —, Mass.Adv.Sh. (1981) 1980, 425 N.E.2d 213, thus rendering the defendants' motion ripe for hearing and decision as a motion for summary judgment. Plaintiffs Kartell, Wilson and Howe filed a motion for partial summary judgment on March 8, 1982. On April 8, 1982, this Court heard oral arguments on both summary judgment motions.

After considering these arguments, as well as the briefs submitted by all parties, I rule that plaintiffs' complaint against Blue Cross and Blue Shield is barred in part by the state action doctrine of *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943). To the extent that plaintiffs' complaint challenges Blue Shield's "ban on balance-billing," discussed *infra*, the complaint is not barred by either the state action doctrine or the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq*, which exempts from the federal antitrust laws "the business of insurance . . . regulated by State law." *Id.*, § 1012(b). I further rule that the "*per se*" standard of antitrust analysis should not be applied to the so-called ban on balance-billing, and that the traditional "rule of reason" standard should be employed.

As a result of these rulings, it follows that defendants' motion for summary judgment should be granted in part and denied in part, and the plaintiffs' complaint should be dismissed in part with prejudice with respect to all defendants, in accordance with the rulings below. It also follows that plaintiffs' motion for partial summary judgment should be denied.

## I. *The Facts*

Although this case has been pending for more than four years, and has been assigned to five different judges of the Court—four of whom have recused themselves—the material facts have not changed since the filing of the complaint or its transfer to the undersigned on March 8, 1982.

Blue Shield and Blue Cross, respectively, are nonprofit, tax-exempt medical service and hospital service corporations, organized to provide "for the preservation of the public health by furnishing medical services at low cost to members of the public who have become subscribers." 1941 Mass.Acts c. 306, preamble. Mass.G.L. c. 176B (Blue Shield); c. 176A (Blue Cross). They are the only corporations of their kind created under their respective enabling statutes.

Blue Shield directly compensates in scheduled amounts those physicians who "participate" in its medical services plan for services rendered to about 96% of Blue Shield's premium-paying subscribers. Participating physicians, in turn, agree to accept Blue Shield's payments in full satisfaction for their services, and not to "balance-bill," *i.e.*, not to seek to recover from Blue Shield subscribers whom they treat any amount in excess of that which Blue Shield has agreed to pay the physician for the service. Except in a few cases not of concern here, Blue Shield does not directly remunerate subscribers in any manner, and does not remunerate non-participating physicians for services rendered to subscribers, unless such services are rendered in an emergency, or outside the Commonwealth.

Blue Cross, on the other hand, is authorized by statute to provide coverage to its subscribers for hospital care and related procedures. Blue Cross does not remunerate any physician for services rendered to Blue Cross subscribers except those physicians who are salaried members of the staffs of institutions, like hospitals, which have entered into agreements with Blue Cross, and those physicians who treat Massachusetts state employees who are subscribers of a Blue Cross plan available only to employees of the Commonwealth.

As permitted by Mass.G.L. c. 176B, § 3, Blue Shield has joined with Blue Cross for the joint administration of their affairs and the issuance of joint subscriber contracts for both medical and hospital services. At this time, defendants' subscribers constitute about 60% of the population of Massachusetts, and about 99% of the Commonwealth's physicians are participating physicians in Blue Shield's medical service plan.

The doctors who are the individual plaintiffs here are all licensed to practice medicine in Massachusetts. All but two are participants in Blue Shield's medical service plan, and all claim to have been materially harmed by certain practices of Blue Cross and Blue Shield.

Specifically, plaintiffs claim that Blue Shield is engaged in illegal price fixing 1) by generally refusing to reimburse physicians who have not signed participating Physicians' Agreements with Blue Shield for services rendered to Blue Shield subscribers, and 2) by requiring that participating physicians (a) accept Blue Shield's reimbursement as payment in full in most cases, and (b) refrain from billing Blue Shield subscribers for any amount in excess of the amount which Blue Shield has agreed to pay participating physicians. Plaintiffs claim that were it not for Blue Shield's so-called ban on balance-billing, participating physicians would be able in many cases to charge and receive higher fees for their services to subscribers. They also claim that Blue Shield's refusal in most cases to compensate either subscribers or non-participating physicians for services rendered by non-participating physicians wrongfully deprives those physicians of potential patients who, but for Blue Shield's policy of excluding non-participating physicians, would turn to non-participating physicians for treatment.

Plaintiffs further allege that Blue Cross has agreed with Blue Shield to refuse to provide benefits to Blue Cross subscribers for services rendered by physicians other than those rendered by the salaried staff of institutional providers, such as hospitals, and those rendered under Blue Cross' contract covering Massachusetts State employees. Plaintiffs claim that this agreement has had the effect of perpetuating Blue Shield's alleged dominance in the market of providing insurance against the costs of physicians' services.

Plaintiffs further allege that Blue Shield directs its subscribers not to use non-participating physicians, and directs participating physicians not to refer patients to non-participating physicians. Blue Cross, according to plaintiffs, directs its participating hospitals not to employ physicians who do not participate in the Blue Shield plan.

## II. *The State Action Exemption*

Judge Skinner initially dismissed the complaint in April 1978 on the ground that the challenged practices are immune from federal antitrust attack under the "state action" exemption recognized in *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).[1] Recognizing that application of the state action doctrine to the facts of this case called for the "[r]esolution of . . . complex questions of state law," the United States Court of Appeals for the First Circuit reversed the ruling dismissing the complaint and instructed Judge Skinner to seek state court guidance in determining the an-

1. "In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." *Parker v. Brown*, 317 U.S. 341, 351, 63 S.Ct. 307, 313, 87 L.Ed. 315 (1943).

swers to these questions, first, by awaiting a forthcoming decision in a related case then pending before the Massachusetts Supreme Judicial Court,[2] and second, if that decision did not present sufficient guidance, to consider "certifying" the relevant questions of state law to the Supreme Judicial Court for that court's consideration. As noted above, questions of state law were eventually certified by Judge Skinner to the Commonwealth's highest court, and were answered by that court in an opinion announced on August 20, 1981. The answers to these questions now enable this Court to determine whether the challenged practices of Blue Shield and Blue Cross constitute "state action," and thus are immune from attack under the federal antitrust laws.

As all parties have noted in their arguments, the state action defense originally announced in *Parker* has been reviewed and restated in two recent decisions of the Supreme Court: *Community Communications Company Inc. v. City of Boulder, Colo.*, —— U.S. ——, ——, 102 S.Ct. 835, 839, 70 L.Ed.2d 810 (1982), and *California Association v. Midcal Aluminum, Inc.*, 445 U.S. 97, 100 S.Ct. 937, 63 L.Ed.2d 233 (1980). The standard articulated in *Midcal*, which was expressly reaffirmed in *Community Communications*, is as follows:

> First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy;' second, the policy must be 'actively supervised by the State itself.'

445 U.S. at 105, 100 S.Ct. at 943 (citations omitted). As noted above, plaintiffs have identified several practices which they claim amount to illegal restraints. The answer of the Supreme Judicial Court to the certified questions clearly disclose whether three of the challenged restraints are "clearly articulated and affirmatively expressed as state policy," and thus meet the first part of the state action test.

II(A). *Question 1(a): The Ban on Balance-Billing*

The first question certified to and answered by the Supreme Judicial Court asks:

> 1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by a clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the Annexed Stipulation [*i.e.*, by requiring the participating physician to accept the fee paid by Blue Shield as payment in full for covered services rendered to Blue Shield subscribers] . . .?

The Supreme Judicial Court ruled that "we find in G.L. c. 176B no affirmative policy requiring, or authorizing the Commissioner to require, such a restraint. We therefore answer question 1(a) in the negative." *Kartell, supra*, —— Mass. at ——, Mass.Adv.Sh. (1981) at 1986, 425 N.E.2d 313.

The court's exhaustive rationale for its answer to question 1(a) includes a concise history of the fee-limitation practice, *Id.* at ——, Mass.Adv.Sh. (1981) at 1986–94, 425 N.E.2d 313, which was culled from the same Stipulation of Facts and Exhibits now before this court, and which merits paraphrase here.

Blue Shield was incorporated as the first and only medical service corporation organized under G.L. c. 176B on May 6, 1942. On September 18, 1942, the Commissioner, pursuant to his powers under c. 176B, gave his approval to the first subscription contract, the first Participating Physician's Agreement,[3] the first schedule of rates to be

2. In this case, *Nelson v. Blue Shield of Massachusetts*, 377 Mass. 746, 387 N.E.2d 589 (1976), the Supreme Judicial Court dismissed the complaint on the grounds that plaintiffs there had failed to exhaust their administrative remedies.

3. This agreement, which remains unchanged to this date, provides in relevant part that:

> "[t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the

charged subscribers, and the first schedule of fees to be paid participating physicians. The original subscription certificate created two classes of subscribers, "unlimited" (those whose personal or family income was below a certain figure, who received under the plan "unlimited" coverage from physicians in return for their premium payments), and "limited" (those whose income was above a certain figure who could be "balanced-billed" by participating physicians for charges in excess of that amount which Blue Shield had agreed to pay participating physicians). In 1951, the "unlimited" class of subscribers was divided into two sub-classes. The sub-class whose membership had higher incomes than those of the lower sub-class also were charged higher premiums; participating physicians received higher payments from Blue Shield for services rendered to subscribers in the higher income group. This subdivision of the "unlimited" group did not affect participating physicians' ability to balance-bill limited subscribers.

In 1956, Blue Cross and Blue Shield initiated the Master Medical Certificate, which provides comprehensive coverage of hospital and medical costs under a single plan, but which did not depart from the income-limit method of determining a subscriber's entitlement to service benefits.

In late 1967, Blue Shield submitted to the Commissioner a proposed "Amended Schedule of Benefits—Blue Shield Portion of Blue Cross—Blue Shield Master Medical Certificate," which introduced the "usual and customary charge" method of compensation. According to the Supreme Judicial Court,

> Blue Shield [by this plan] proposed to substitute for fixed fee schedules a system under which participating physicians would receive 95 percent [5 percent would be subtracted by Blue Shield to cover administrative costs] of the lesser of their usual charge, or the customary charge, for a particular service. The usual charge is calculated by determining the median of all fees charged by a particular physician for a specific service during each six month reporting period. Similarly, the customary charge is established as the mean of all fees reported for a particular service by physicians of like experience and training during each reporting period.

*Id.* at ——, Mass.Adv.Sh. (1981) at 1987–88, 425 N.E.2d 313. While participating physicians under the usual and customary method of compensation are required to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income, the advantage to participating physicians of this system (at least in the late 1960s, when lagging Blue Shield fee adjustments were reducing physicians' real compensation because of inflation) was the "promise of higher fees immediately for many services and relatively automatic future adjustments for inflation." *Id.* at ——, Mass.Adv.Sh. (1981) at 1988, 425 N.E.2d 313.

The Commissioner approved the revision of the Master Medical Certificate effective February 1, 1968, and through 1975 Blue Shield "updated usual and customary charges as it deemed appropriate without objection from the Commissioner." *Id.* In 1976, no updating was proposed by Blue Shield due to the fact that its reserves had decreased from $26 million to $1 million during the eighteen months preceding May of 1976. Blue Shield proposed an update of the charges in 1977, which was approved by the Commissioner subject to the qualification that increases in the usual and customary fees not exceed 7 and 4 percent, respectively. In 1978, the Commissioner took the position that updates in the usual and customary fees must receive his prior written approval, which was withheld for the 1978 proposed increases. Thus, the 1977 fee schedules have remained in effect to this date.

In answering question 1(a), the Supreme Judicial Court focused on two elements. The court first examined the language and statutory history of Mass.G.L. c. 176B, and

fee schedule in effect at the time the services are rendered."

arrived at the "inescapable" conclusion that "no one familiar with the legislative scheme, either at its inception or immediately prior to the adoption of the present method of compensation, believed that it required the near universal provision of service benefits [*i.e.*, the ban on balance-billing] which is now subject to challenge." The Supreme Judicial Court thus ruled that Blue Shield's near-universal ban on balanced-billing was nowhere "compelled" by the statute in question.

The Supreme Judicial Court similarly found that because § 4 of c. 176B gives the Commissioner the power only to *disapprove* of Blue Shield's methods of compensation if they are outside the range of reasonableness, but not to establish those methods, the Commissioner's "approval in 1967 of the usual and customary method of compensation does not constitute State action for the purposes of anti-trust immunity." *Id.* at ——, Mass.Adv.Sh. (1981) at 1993, 425 N.E.2d 313.

Defendants here do not challenge the Supreme Judicial Court's negative answer to question 1(a) as that question was put to the court. They rather contend that the Supreme Judicial Court's rationale requires a finding by this Court that a method of compensation which prohibits participating physicians from balance-billing low- and middle-income subscribers (who the Supreme Judicial Court has ruled were intended by the legislature to be the beneficiaries of c. 176B) is compelled by the statute or by state policy as articulated and implemented by the Commissioner. The defendants' reading of the Supreme Judicial Court's rationale, if accepted, would insulate from antitrust challenge the usual and customary method of compensation as it pertains to low- and middle-income subscribers, leaving for antitrust scrutiny only that part of the method which applies to upper-income subscribers.

[1, 2] I decline to adopt the defendants' contention. While it is beyond doubt that Mass.G.L. c. 176B is primarily intended to insure that affordable health insurance will be available to low- and middle- income residents of the Commonwealth, I find no state law or policy which requires either the Commissioner or Blue Shield to prohibit balance-billing for *any* income-class of subscribers. I adopt the rationale of the Supreme Judicial Court, and rule that no " 'clearly articulated and affirmatively expressed . . . state policy,' " *Midcal, supra*, 445 U.S. at 105, 100 S.Ct. at 943, compells the use by Blue Shield of the usual and customary charge method of compensation to participating physicians. As a result, I rule that this practice cannot be shielded from scrutiny under the federal antitrust laws under the state action doctrine of *Parker* and *Midcal*.

II(B). *Question 2(a): The "lock-out" of non-participating Physicians*

The second question certified to the Supreme Judicial Court asks:

> 1. Is Blue Shield of Massachusetts, Inc., compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy . . . (b) to refuse to make payment for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including limitation of such fees?

Finding that "[b]y contrast to question 1(a), question 1(b) involves a relatively straightforward process of statutory construction," —— Mass. ——, (1981) Mass.Adv.Sh. at 1994, 425 N.E.2d 313, the Supreme Judicial Court ruled "that G.L. c. 176B, § 7, precludes payments by Blue Shield to non-participating physicians for services rendered to subscribers except in cases of emergency or for services rendered outside the State." *Id.*

The Supreme Judicial Court explained its ruling in the following passage:

> General Laws, c. 176B, § 7, as appearing in St. 1978, c. 574, § 3 provides in relevant part that "*[a] subscriber or a covered dependent*, subject to the by-laws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, *shall be*

*entitled to the benefits of this chapter upon receiving medical . . . service from any participating physician . . . or,* in the discretion of the corporation, *upon receiving medical . . . service from any non-participating physician . . . in an emergency or when outside the Commonwealth*" (emphasis added). A nonprofit medical service plan is defined by G.L. c. 176B, § 1, as "a plan operated by a medical service corporation . . . whereby the cost of medical . . . service . . . furnished to subscribers and covered dependents is paid by the corporation . . . to participating physicians . . . and to such other physicians as are provided for herein . . ." Finally, a participating physician is defined as "a registered physician . . . who agrees in writing with a medical service corporation to perform medical service for subscribers and covered dependents and to abide by the by-laws, rules and regulations of such corporation." G.L. c. 176B, § 1. These sections, read together, indicate a clear legislative purpose to limit the advantages of reimbursement by Blue Shield—principally the guarantee of prompt payment at a fixed rate—to those physicians who choose to participate in the program.

The Supreme Judicial Court analyzed and rejected the plaintiffs' argument that § 7 of c. 176B merely limits the benefits to which subscribers are entitled, but in no way compels Blue Shield to refuse reimbursement to non-participating physicians for non-emergency services rendered in the Commonwealth.[4] In rejecting this argument, the Court discussed the origins of Blue Shield, highlighting matters of significance to this and later parts of this opinion. The Supreme Judicial Court said:

> To the extent that the language of § 7 is ambiguous, the ambiguity is resolved by reference to the structure and history of the Blue Shield program as a whole. The critical language of § 7 was included in the initial bill submitted by the Medical Society to authorize the formation of nonprofit medical service corporation, as well as in the successor bill which was ultimately enacted as G.L. c. 176B. The participating physician concept was integral to the original vision of the manner in which medical service plans would operate. Because medical service corporations were to be formed and operated by the medical profession itself, rather than by commercial insurance companies, the drafters of the enabling legislation were faced with the problem of either accumulating the financial reserves required to guarantee the soundness of the program, or finding some acceptable substitute. This problem was addressed by means of the "unit system", under which participating physicians themselves acted as underwriters of risk.
>
> The system was presented to the Commission of Insurance, in a statement from the Medical Society, as a substitute for the reserve requirements of traditional insurance plans. The Medical Society's statement to the Commissioner argued that the unit system "constitutes an actuarial substitute for the necessary large financial reserves of profit-making commercial corporations . . . This is necessary in commercial corporations because [financial demands] are directly related to contractually binding, inflexible indemnity schedules. Thus there is substituted in Massachusetts Medical Service, Inc. [now known as Blue Shield of Massachusetts, Inc.] for such large financial reserves, a guaranteed medical-service reserve to the subscribers during the terms of the contract, by participating physicians who accept an unguaranteed and fluctuating

4. After having argued to the Supreme Judicial Court that c. 176B, § 7, prohibits the payment of benefits to *subscribers*, and *not* to non-participating physicians, plaintiffs argue before this court that c. 176B, § 7, prohibits the payment of benefits to *non-participating physicians*, but does not prohibit the payment of benefits to subscribers for services rendered by non-participating physicians. I rule that such an attempted end around reverse of the Supreme Judicial Court's clearly-reasoned answer to the question put to it by this Court should be stopped with no gain, for the Supreme Judicial Court's rationale, which is quoted in the body of this opinion, disposes of *both* of plaintiffs' argument on this issue.

schedule of indemnification, the current monetary equivalent of which at any time is determined by an equitable proration of available earned income among the participating physicians" (emphasis added).

The original Participating Physician's Agreement, approved by the Commissioner of Insurance on September 18, 1942, contained the following clause: "Unit System: In the event that the amount available in any accounting period for distribution to Participating Physicians . . . shall be insufficient to pay all Participating Physicians in full, then the amount which the Board of Directors decides is available for distribution shall be paid to all Participating Physicians on a pro rata basis." This agreement remains in use at present.

Obviously, the potential benefits to physicians stemming from participation in the plan were accompanied by an element of risk. Had physicians been free to obtain payment for services to subscribers without incurring the risk of reduced payment under the unit system, there would have been little incentive to participate.

*Id.* at —, Mass.Adv.Sh. (1981) at 1995–96, 425 N.E.2d 313. The Supreme Judicial Court concluded its analysis of question 1(b) by stating that "[a]gainst this background, we think it clear that the Legislature intended by G.L. c. 176B, § 7, to limit Blue Shield's system of reimbursement to participating physicians, except in those circumstances in which such services could not reasonably be obtained." *Id.* at —, Mass. Adv.Sh. (1981) at 1996, 425 N.E.2d 313.

[3] In light of this controlling interpretation of state law made by the highest court of the Commonwealth, I rule that Blue Shield's practice of restricting to participating physicians remuneration for services rendered to subscribers is " 'clearly articulated and affirmatively expressed as state policy,' " *Midcal, supra*, at 105, 100 S.Ct. at 943, and therefore satisfies the first part of the state action test.

The intervenor plaintiffs claim that Blue Shield's general practice of not remunerating non-participating physicians cannot pass the second part of the state action test, which requires that the challenged restraint "be 'actively supervised' by the State itself." *Id.* They claim that their argument is supported by the fact that Blue Shield subscriber contracts provide that remuneration will be provided to non-participating physicians in the event of emergency, or for services rendered outside of Massachusetts, and then only when the services of a participating physician are not reasonably available, and at the discretion of Blue Shield. There is, however, nothing in plaintiffs' complaint which shows that they are challenging under the antitrust laws the procedure by which Blue Shield determines whether services rendered to a subscriber by a non-participant were rendered in an emergency situation or out-of-state, or whether the services of a participating physician was not reasonably available. Plaintiffs instead are challenging the larger Blue Shield practice of normally remunerating only participating physicians.

[4, 5] I rule that since the challenged Blue Shield practice of generally excluding non-participating physicians from remuneration is compelled by c. 176B, § 7, it a *fortiori* passes the second part of the state action test, and is as a result immune from federal antitrust scrutiny under the state action doctrine of *Parker, supra*, and its progeny. Plaintiffs argue that in *Corey v. Look*, 641 F.2d 32 (1st Cir. 1981) the United States Court of Appeals for the First Circuit recently articulated a third rung of the state action test which requires that "the [entity] . . . claiming [state action] exemption illustrate the requisite state legislative intent by demonstrating by convincing reasoning that the challenged restraint is necessary to the successful operation of the legislative scheme that the state sovereign has established." The court in *Corey* ruled that this showing must be made only in cases where "explicit" statutory language was "absent." *Id.* Given the clear language of c. 176, § 7, and the state court's finding that "question 1(b) involves a relatively straightforward process of statutory

construction," I rule that the test articulated in *Corey* need not be considered herein.

Insofar as plaintiffs' complaint challenges this Blue Cross practice, the complaint should be dismissed.

II(C). *Question 2: Blue Shield Forebearance From Generally Providing Benefits for Physician's Services*

The third question certified to the Supreme Judicial Court asks:

> 2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?

One of plaintiffs' theories in this law suit is that Blue Cross has failed to generally provide coverage for its subscribers for services rendered by physicians, other than those services rendered by the salaried staff of institutional providers such as hospitals. Plaintiffs suggest that this failure suggests the existence of an illegal conspiracy between Blue Cross and Blue Shield which allows Blue Shield to dominate the market of health insurance for treatment by physicians. That Blue Cross could offer such coverage under its enabling laws, according to plaintiffs, is demonstrated by the fact that such coverage is provided for those Blue Cross subscribers who are employees of the Commonwealth.

[6] In ruling that the laws of Massachusetts do *not* generally permit such coverage, the Supreme Judicial Court articulated the following rationale, which I adopt:

> To respond to Question No. 2 it will be helpful to recast the question into two questions: (a) Is Blue Cross empowered under G.L. c. 176A to cover physicians' services under the caption "other health services" as that phrase is used in G.L. c. 176A, § 7? (b) By what authority is Blue Cross authorized to contract directly with the Commonwealth to cover services of physicians?

The first question (a) must be answered "no." Blue Cross was permitted to provide benefits only for hospital services until 1953. In that year the Legislature amended G.H. c. 176A, § 1, to permit a hospital service corporation to provide "reimbursement for other health services." St. 1953, c. 287, § 1. These "other health services" have included such non-hospital providers as visiting nurse associations, mental health clinics and home health agencies. Authorization for these contracts is found in the fourth paragraph of G.L. c. 176A, § 5.

It has been stipulated that Blue Cross has never provided benefits for physicians' services except (1) covered services rendered by salaried staff physicians of hospitals and certain other institutional provides with which it has contracts; and (2) nonemergency, in-State service rendered by participating and non-participating Blue Shield physicians under the State employees' contract.

The Master Medical Certificate issued to subscribers provides that "[b]enefits contained herein for all services and supplies other than those furnished by a physician, dentist, podiatrist, or psychologist shall be provided by Blue Cross," and that "[b]enefits contained herein for services of a physician, dentist, podiatrist, or psychologist shall be provided by Blue Shield."

It is highly unlikely that the Legislature would authorize Blue Cross and Blue Shield to sail on a collision course of competition for subscribers for coverage of physicians' services when Blue Cross's principal course is directed towards hospital services and Blue Shield's towards physicians' services. Equally improbable is a legislative intent to permit Blue Cross to provide the benefits of a full range of physicians' services on a non-participating basis and thereby escape the network of regulation found in G.L. c. 176B. In short, Blue Cross is not empowered to cover physicians' services except in those instances already noted.

The answer to the second question (b) can be found in G.L. c. 32A, § 4. Blue Cross

is authorized to contract with State employees because the Legislature vested it with such authority. Under this statute, the Group Insurance Commission is authorized to enter into an agreement for insurance coverage for State employees with Blue Cross "in the same manner as any other insurance company."

The authority for contracts with State employees reposes in G.L. c. 32A in the first instance, and not in G.L. c. 176A. The express reference of G.L. c. 176A in G.L. c. 32A, § 4 encourage us to rule that such provision is special and thus, absent a contrary legislative intent, it must prevail over conflicting provisions, if any, in G.L. c. 176A and c. 176B. . . . Accordingly, we respond to this question by recognizing that payments to physicians for medical services under the contract between Blue Cross and the Group Insurance Commission are authorized by the express language of G.L. c. 32A, § 4, and, as such, this coverage does not derogate from the exclusiveness of Blue Shield's coverage for physicians' services to subscribers who are not under the contract insuring State employees.

*Id.* at ——-——, Mass.Adv.Sh. (1981) at 1996–1998, 425 N.E.2d 313. Since general forebearance from the insurance market covering physician's services is clearly required of Blue Cross by state statutes as described above by the Supreme Judicial Court, I rule that this practice satisfies both prongs of the *Midcal* test, and thus is immune under the state action doctrine from antitrust challenge.[5] Thus plaintiffs' complaint should be dismissed insofar as it challenges Blue Cross' forebearance from this market.

III. *The McCarran-Ferguson Act*

Since this Court has ruled that the agreement of Blue Shield and participating physicians to use the usual and customary method of physician compensation is not immune from antitrust scrutiny under the state action doctrine, we now turn to defendants' claim that this agreement is exempt from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015.

[7] To establish that the agreements between Blue Shield and its participating physicians are within the protection of the Act, Blue Shield has the burden of meeting three separate tests. First, the agreements must be shown to be the "business of insurance," 15 U.S.C. § 1012(b), as that statutory term has been interpreted by case law since the passage of the Act 40 years ago. Second, the agreements must be "regulated by State law" as required by § 2(b) of the Act. *Id.* Third, "any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation" is outside the Act's exemptive powers, and remains subject to the antitrust laws. The undisputed facts at this point must show an absence of any such agreement or action before the defendants may be awarded summary judgment on this issue.

Plaintiffs claim that a recent Supreme Court case, *Group Life and Health Insurance Company v. Royal Drug Company*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979), clearly establishes that the agreements in question here are not the "business of insurance" as required by the Act. The Supreme Court in that case was confronted with a scheme whereby Blue Shield of Texas offered insurance policies which entitled the policyholder to obtain prescription drugs from both participating and non-participating pharmacies. If a prescription were obtained under this plan from a participating pharmacy, the insured paid $2 to the pharmacy for the prescription; the pharmacy's wholesale cost was paid to the participating pharmacy directly by Blue Cross. Thus the highest price a participating pharmacy could obtain on prescription sold to a Blue Shield policyholder was its wholesale cost plus $2. If the prescription were obtained from a non-participating pharmacy, the insured paid the entire price charged by the pharmacy to the pharmacy, and was reimbursed by Blue Shield for 75% of the difference between the actual price

5. *See* discussion of *Corey v. Look*, *supra*.

and $2. Thus non-participating pharmacies were not limited in the amount that they could charge Blue Shield subscribers.

Suit was brought against Blue Shield by a group of pharmacy owners who alleged that the agreements entered into by Blue Shield and the participating pharmacies amounted to the type of price fixing banned by § 1 of the Sherman Act. The United States District Court for the Western District of Texas granted summary judgment to Blue Shield on the grounds that the agreements met all three tests of the McCarran-Ferguson Act. Upholding the reversal of the trial court by the United States Court of Appeals for the Fifth Circuit, the Supreme Court ruled that the agreements in fact did not amount to the "business of insurance," and thus were not within the protection of the Act. *Id.* at 211–15, 99 S.Ct. at 1073–1075.

In so holding, the Court articulated what amounts to a two part test that procurement agreements similar to the one examined in *Royal Drug* must meet in order to be considered the "business of insurance." First, the agreement must be concerned in part with the "spreading and underwriting of a *policyholder's* risk." *Id.* at 211, 99 S.Ct. at 1073 (emphasis added). Second, since the "business of insurance" is "commonly understood" to focus on " 'the relationship between the insurance company and the policyholder' ", *Id.* at 215–16, 99 S.Ct. at 1075, *quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969), the agreements must themselves focus at least in part on the relationship between the insured and the insurer, and not merely on contractual arrangements for the procurement of goods and services.

The Court ruled that the agreement between Blue Shield of Texas and participating pharmacies could not pass either test, and thus were not part of the "business of insurance." The agreements, the Court said, "serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations" to its policyholders. *Id.* at 213, 99 S.Ct. at 1074. As long as Blue Shield is able to keep its contractual obligation to its policyholders that they will not have to pay more than $2 per prescription to participating pharmacies, "policyholders are basically unconcerned with the arrangements made between Blue Shield and participating pharmacies." *Id.* at 214, 99 S.Ct. at 1074. The court continued:

> By agreeing with pharmacies on the maximum price it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-saving arrangements may well be sound business practice, and may well insure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the business of insurance.

*Id.*

[8] The agreements between Blue Shield and participating physicians challenged here by plaintiffs are in substance the same as those agreements which were ruled to be outside the realm of the "business of insurance" in *Royal Drug*, with one exception—a difference which Blue Shield argues brings these agreements within the *Royal Drug* definition of the "business of insurance." As was described in detail by the Supreme Judicial Court of Massachusetts in excerpts from its *Kartell* decision reproduced above, the "unit system," by which participating physicians agree to be compensated for their services rendered to Blue Shield subscribers on a *pro rata* basis if Blue Shield is unable at any time to compensate participating physicians in full because of a depletion of Blue Shield funds, has been an integral part of the agreement between Blue Shield and participating physicians since the creation of Blue Shield 40 years ago. Blue Shield argues that "[u]nlike the pharmacy agreements at issue in *Royal Drug*, Blue Shield's agreements with its participating physicians [by inclusion of the unit system] place underwriting risk on the physicians." Plaintiffs counter that the "unit system" is a "relic" of the early years of Blue Shield, and make much

of the fact that Blue Shield has never in its history had to resort to *pro rata* compensation because of a depletion of its funds. I concur with Blue Shield and the Supreme Judicial Court that the unit system remains an integral part of the larger Blue Shield plan, and continues to place some amount of risk on participating physicians. That this risk is perhaps a significant risk is underscored by the fact that, as noted above, Blue Shield in 1976 made the decision not to upscale its usual and customary fee schedule in 1976 due to the fact that its funds available for physician compensation had dramatically dropped from $26 million to $1 million in an 18-month period.

[9, 10] I further rule that the fact that the "unit system" forces participating physicians to carry some risk is not enough by and of itself to satisfy the first test of *Royal Drug*. The risk accepted by the participating physicians is the risk that at any time Blue Shield may not have sufficient reserves to satisfy participating physicians' claims for remuneration. This is a risk which, absent the participating physicians' agreement to carry it, would be carried by Blue Shield, not by the subscribers. By agreeing to carry the risks inherent in the "unit system," participating physicians no doubt enable Blue Shield to cut the costs of maintaining the higher reserves that private insurance companies not able to employ the unit system must maintain. As is noted above, this is the result the Supreme Judicial Court found was intended by the state legislature in including the unit system in c. 176B. And it is also true that these lower costs may result in lower subscriber premiums. But the Supreme Court has ruled in *Royal Drug* that the fact that an agreement between an insurance company and a third party may result in lower premiums to policyholders is not enough to qualify that agreement as the "business of insurance." As the court stated, "The [McCarran-Ferguson Act] exemption is for the 'business of insurance,' not the 'business of insurers.'" *Id.* at 211, 99 S.Ct. at 1073. I therefore rule that the agreements here in question between Blue Shield and participating physicians do not qualify as the "business of insurance," and thus are not exempt from the federal antitrust laws under the McCarran-Ferguson Act.

IV. *Plaintiffs' Motion for Partial Summary Judgment*

Plaintiffs claim that the general ban on balance-billing contained in Blue Shield's agreements with its participating physicians constitutes a violation of § 1 of the Sherman Act, and have moved for partial summary judgment on this issue pursuant to Fed.R.Civ.P. 56. The question of whether agreements such as the one examined here are violations of § 1 is currently being litigated in at least two other federal courts (see discussion below), and the Supreme Court recently stated that it has not yet been presented with this exact question, and thus has not yet expressed an opinion on whether these agreements are in violation of the Sherman Act. *Arizona v. Maricopa County Medical Society*, —— U.S. ——, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982), Opinion of the Court, n.26.

[11] After considering all of the parties' oral arguments and briefs on this issue, I rule that this agreement does not rise to the level of a *per se* violation of the Sherman Act, and that the facts have not been sufficiently developed at this point in time to allow a proper determination to be made as whether the agreement violates the "rule of reason" standard which more commonly is used to determine violations of § 1. Consequently, plaintiffs motion for partial summary judgment should be denied.

[12] The words of § 1 of the Sherman Act make unlawful "[e]very contract, combination . . ., or conspiracy, in restraint of trade or commerce among the several States." 15 U.S.C. § 1. Plaintiffs' primary theory of Blue Shield's § 1 liability is that the ban on balance-billing is *per se* violative of § 1. Antitrust case law has determined that restrictive agreements which are "manifestly anticompetitive" are violative *per se* of § 1. *See, e.g., Continental T.V. Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36,

49–50, 97 S.Ct. 2549, 2557, 53 L.Ed.2d 568 (1977); *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958). Plaintiffs here claim that the agreements between Blue Shield and its participating physicians are similar to agreements which have been struck down by the Supreme Court as "manifestly anticompetitive" despite the fact that the agreements set maximum as opposed to minimum prices at which the goods in question may be sold to third parties. *Albrecht v. Herald Co.*, 390 U.S. 145, 88 S.Ct. 869, 19 L.Ed.2d 998 (1968) (publisher's establishment of maximum resale price of newspapers sold by carriers held *per se* violative of § 1); *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S.Ct. 259, 95 L.Ed. 219 (1951) (distiller's agreement on maximum resale price of liquor sold by distillers held *per se* violative of § 1). Plaintiffs correctly point out that the *per se* prohibition of § 1 applies as much to professional services such as medical treatment as it does to the "commodities" involved in the cases cited above. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 786–788, 95 S.Ct. 2004, 2013, 44 L.Ed.2d 572 (1975).

Blue Shield, on the other hand, argues that the *per se* standard should not be applied to its agreements with participating physicians, and relies for support on recent cases from the United States Court of Appeals for the Second Circuit and the United States District Court for the Northern District of California. In *Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 675 F.2d 502 (2d Cir. 1982), the Court of Appeals for the Second Circuit upheld a decision of the United States District Court for the District of Connecticut by ruling that agreements between Blue Cross and participating pharmacies in which the maximum prices that the pharmacies could charge Blue Cross subscribers was set were not *per se* violative of § 1. The agreements in this case were almost duplicates of the agreements examined by the Supreme Court in the *Royal Drug* case, discussed above, in that Blue Cross subscribers who patronized "participating" pharmacies (*i.e.*, those who had entered into agreement with Blue Cross) were required at most to pay the pharmacy a small "deductible" amount, and the pharmacy was reimbursed by Blue Cross at the rate established in the agreement; subscribers who patronized non-participating pharmacies paid the pharmacies the over-the-counter prices for prescriptions, and were reimbursed by Blue Cross at the rate established in the subscriber agreement with Blue Cross.

In finding that the agreements were not *per se* violative of § 1, the district court distinguished the case before it from cases in which agreements fixing maximum prices had been struck down as unlawful. The court found that Blue Cross was in fact a bulk purchase of drugs for its subscribers; thus the agreements between Blue Cross and the participating pharmacies did not restrain the pharmacies from setting their own price for their goods and services to third parties. *Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 518 F.Supp. 1100, 1107 (D.Ct.1981). *See Sitkin Smelting & Refining Co., Inc. v. FMC Corp.*, 575 F.2d 440, 446 (3d Cir.), *cert. denied*, 439 U.S. 866, 99 S.Ct. 191, 58 L.Ed.2d 176 (1978) (the *per se* rule applies to "an agreement to fix the price to be charged in transactions with third parties, not between the contrasting parties themselves"). On appeal, the plaintiff argued that only the Blue Cross subscriber could be viewed as the purchaser of prescriptions from participating pharmacies. In ruling that the district court properly refused to apply the *per se* standard, the Court of Appeals for the Second Circuit stated that

> even if Blue Cross cannot be characterized as the purchaser for the purpose of antitrust analysis, we consider the pharmacy agreements to be sufficiently different from the maximum price-fixing agreements struck down in *Albrecht* and *Kiefer-Stewart* to preclude application of the *per se* rule. . . . Whether Blue Cross is characterized as a purchaser or as an indemnitor or third party payor, it is the ultimate payor, and therefore its pre-

scription drug plan differs significantly from the vertical arrangements to restrict prices that [have been] invalidated.

675 F.2d at 505–6. After noting that the "pharmacy agreements are novel restraints, with potential procompetitive effects," and citing several cases and law review articles for the proposition that the *per se* rule should not be lightly applied to business relationships with a potential for enhancing competition, the court ruled that the district court properly determined that the agreements must be analyzed under the lower "rule of reason" standard. *Id.* at 505.

[13] I find the reasoning of the Second Circuit in this case to be cogent and persuasive. The restrictive agreements here challenged by the plaintiffs do not differ in substance from the agreements scrutinized in *Medical Arts Pharmacy*.[6] That the entities entering into the agreements are here doctors, as opposed to pharmacists, and that the subject matter of the agreements here involves the rendering of medical services, as opposed to the sale of prescription drugs, are distinctions without differences for purposes of determining under the antitrust laws whether Blue Shield is the "ultimate payor" of the services whose price has been fixed, and thus has the ability to restrict the price that can be received for those services. I therefore rule that the agreements here challenged by the plaintiffs should be examined under the traditional rule of reason standard to determine whether they are in violation of § 1 of the Sherman Act. *Accord: Sausalito Pharmacy, Inc. v. Blue Shield of California*, 1980–81 CCH Trade Cases 77, 722 (N.D.Cal.1980) ("*Sausalito I*"), and 1981–2 CCH Trade Cases 75, 604 (N.D.Cal.1981) ("*Sausalito II*").

[14] Both plaintiffs and Blue Shield argue in their respective memoranda in support of their summary judgment motions that they should prevail under the rule of reason analysis. This standard "requires the factfinder to determine whether, under all of the circumstances of the case, including the facts peculiar to the business and the history of, reasons for, and market impact of the restraint, the restrictive practice imposes an unreasonable restraint on competition." *Medical Arts, supra*, at 504. In light of the very limited discovery that has taken place in this case despite its four-year life-span, I rule that sufficient facts have not yet been developed to allow a proper determination under the rule of reason standard. Therefore, both plaintiffs' and Blue Shield's motions for summary judgment on this issue should be denied and an order will enter directing the parties to conduct discovery on this issue. The discovery must be completed by November 1, 1982.

## V. *Conclusion*

As stated above, two of defendants' practices here challenged under the Clayton and Sherman Acts are immune from federal antitrust scrutiny. These practices are Blue Shield's refusal, with limited exceptions, to compensate non-participating physicians for medical services rendered to its subscribers, and Blue Cross' forebearance generally for the medical service insurance market inhabited by Blue Shield. Blue Shield's practice of requiring its participating physicians not to charge Blue Shield subscribers any amount over and above that which Blue Shield has previously agreed to

6. Plaintiffs claim that *Medical Arts* can be distinguished from the case before the Court because [1] the Blue Cross scheme in *Medical Arts* (unlike the Blue Shield scheme here) allowed subscribers to be at least partially remunerated for subscriptions obtained from non-participating pharmacists; and [2] that the district court judge specifically found in *Medical Arts* that Blue Cross occupied only about 9% of the relevant market, as opposed to Blue Shield's occupation of 60% or more of the relative market here. I first note that this finding by the court was made during its "rule of reason" analysis and was not mentioned by the court during its examination of the *per se* approach. 518 F.Supp. at 1103, n.9. In any event, neither of these considerations are relevant to the inquiry of whether the *per se* standard should be applied; both, of course, may be highly relevant (as they were in *Medical Arts* at both the trial and appellate stages) to the determination of whether the restrictive agreements violate the "rule of reason."

pay them on behalf of its subscribers is not exempt from antitrust challenge under either the state action doctrine or the McCarran-Ferguson Act. This Court, however, will at the appropriate time apply to this practice the "rule of reason," as opposed to the *per se* standard of antitrust analysis.

Order accordingly.

Massachusetts General Laws

Chapter 176B, § 7

**§ 7. Agreement Between Corporation and Participating Physician or Chiropractor; Influencing Choice of Physician; Termination; Discrimination Against Chiropractors Prohibited.**

Every registered physician and every registered chiropractor shall have the right, on complying with such rules and regulations as the corporation may make, to enter into a written agreement with a medical service corporation, doing business in the city or town where the said physician or chiropractor resides or has his usual place of business, to perform medical or chiropractic services. This chapter shall not change the normal relations between physician or chiropractor and patient. No restriction shall be placed by any such corporation upon its participating physicians or participating chiropractors as to methods of diagnosis or treatment. No officer, agent, or employee of a medical service corporation shall influence or attempt to influence a subscriber or a covered dependent in his choice of a participating physician or participating chiropractor. A subscriber or a covered dependent, subject to the bylaws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, shall be entitled to the benefits of this chapter upon receiving medical or chiropractic service from any participating physician or participating chiropractor or, in the discretion of the corporation, upon receiving medical or chiropractic service from any non-participating physician or chiropractor in an emergency or when outside the commonwealth. A corporation may terminate its agreement with any participating physician or participating chiropractor or any other participating provider of health services licensed under the laws of the commonwealth

at any time (a) for failure to comply with the reasonable rules and regulations of such corporation, including without limitation such rules and regulations as may be adopted governing the keeping of accounts, records and statistics, the making of reports and proof of services rendered, or (b) for presenting any fraudulent, unreasonable, or improper claim for payment, or compensation.

Nothing in section four or in this section shall be construed to prohibit any medical service corporation from entering into written agreements with its subscribers and with participating chiropractors to furnish chiropractic services to subscribers and covered dependents or from including chiropractic services in its nonprofit medical service plan, nor shall any medical service corporation discriminate in any way against participating chiropractors in the furnishing of chiropractic service to its subscribers and covered dependents. (Amended in 1978, 574, § 3, approved July 22, 1978, effective 90 days therefter; 1981, 623, § 2, approved December 11, 1981, effective 90 days thereafter.)

THE COMMONWEALTH OF MASSACHUSETTS

ADVANCE COPY 1984 ACTS AND RESOLVES

MICHAEL JOSEPH CONNOLLY, SECRETARY OF STATE

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Chap. 192. AN ACT RELATIVE TO MEDICAL SERVICE CORPORATIONS.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to immediately insure the continued delivery of health services in the commonwealth, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

Be it enacted, etc., as follows:

SECTION 1. Section 7 of chapter 176B of the General Laws, as most recently amended by section 2 of chapter 623 of the acts of 1981, is hereby further amended by inserting after the first sentence the following sentence: — No participating physician or participating provider of health services shall charge to or collect from a subscriber or covered dependent any amount in excess of the amount of compensation determined and allowed by a medical service corporation pursuant to the applicable method of compensation approved by the commissioner, except when such subscriber or covered dependent (*a*) is eligible for benefits under a subscription certificate containing a provision permitting such charge or collection when the subscriber or covered dependent (*i*) is entitled to receive reimbursement or compensation from a third party for the cost of the same or similar services or (*ii*) receives money

or its equivalent as a result of a claim against a third party for loss or damages for personal injuries, and only in the circumstances and to the extent so permitted, or (*b*) is eligible for benefits under a subscription certificate which provides for compensation to a participating physician or other participating provider of health services under a nonprofit medical service plan previously approved by the commissioner, the so-called "Plan B", and has an annual income in excess of seven thousand five hundred dollars, or (*c*) is eligible for benefits under a subscription certificate under a group medical service agreement containing a provision describing the specific circumstances under which and the extent to which additional amounts may be charged or collected; provided, however, that such provision has first been approved in writing by the commissioner and has been requested by the employer, employers or other representatives of the group to which it applies, and only in the circumstances and to the extent so described.

SECTION 2. A special commission to consist of six members of the Senate, eleven members of the House of Representatives, the Secretary of Consumer Affairs and Business Regulations or his designee, the President of the Massachusetts Medical Society or his designee, and four persons to be appointed by the Governor, one of whom shall be a representative of Blue Shield of Massachusetts, one of whom shall be a representative of Blue Cross of Massachusetts, one of whom shall be a representative of the Life Insurance Association of Massachusetts, one of whom shall be a representative of organized labor. The special commission is hereby established to make an investigation and study of the laws relating to nonprofit hospital services corporations and nonprofit medical services corporations, as established pursuant to chapters one hundred and seventy-six A and one hundred and seventy-six B of the General Laws. Said commission shall, in the course of its investigation and

study, consider, among other questions it deems relevant, the tax, reimbursement and regulatory status of said corporations in Massachusetts, their standing in relationship to other health care insurers and nonprofit medical services corporations within and without the Commonwealth, to government programs of health insurance, and to competing and alternate forms of health care financing. Particular attention shall be paid to the corporations' rights to contract with professional an other noninstitutional providers of health care services, the system of payments made by said corporation, including the impact of the prohibition on the practice of balance billing, so-called, the financial and accounting procedures of said corporations and their impact on the quality and cost of health care services.

Said commission may expend for expenses and for legal, actuarial, research, clerical and other assistance such sums as may be appropriated, therefor, not to exceed two hundred thousand dollars annually; provided, however, that all costs of administration and operation of said commission shall be borne by nonprofit hospital service corporations established pursuant to chapter one hundred seventy-six A of the General Laws, nonprofit medical service corporations established pursuant to chapter one hundred and seventy-six B of the General Laws, the Massachusetts Medical Society, and the Life Insurance Association of Massachusetts. The secretary of the office of consumer affairs and business regulations shall apportion the estimated costs of said commission on said organizations on a fair and reasonable basis. Said estimated costs shall be paid to said secretary within thirty days after notice from said secretary of such estimated costs. Said secretary shall subsequently apportion actual costs among all said organizations and shall make assessment adjustments for the same for any variation between estimated and actual costs on a fair and reasonable basis. Such estimated and actual costs shall include an amount equal to the cost of fringe benefits as established by

the commissioner of administration pursuant to section six B of chapter twenty-nine of the General Laws.

Said commission shall meet at least quarterly, may report from time to time to the general court, and shall file the results of its investigation and study, and its recommendation, if any, together with drafts of legislation necessary to carry its recommendations into effect with the clerk of the house of representatives in its first annual report no later than July first, nineteen hundred and eighty-five, and shall file its final report on or before December thirty-first, nineteen hundred and eighty-five.

Approved July 12, 1984.